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MEDICAL EDUCATION IN SOUTH AFRICA OVER THE PAST FIFTY YEARS

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The physician of the middle ages, if he was a man of merit, was not a physician only. He was also a philosopher, a mathematician, and an astronomer. He was a Latin scholar too if not always versed in Greek. All learning was his province or, as it used to be said, nothing of human interest was foreign to him. At the turn of the century and even up to the time of the First World War the sum total of medical knowledge was not beyond the capacity of the scholarly medical man. Men like Osler could at the same time hold their own in other scholarly circles.

But today the corpus of medical knowledge has become so enormous that no man can master it all. This brings us to one of the major medical educational problems of today: What is to be taught to undergraduates and what is to be left out? Even 50 years ago teachers used to say that, obviously, they could not teach the whole of medicine. But the problem was easily manageable then.

Medicine has not merely grown in bulk. It has also changed its complexion. There is a much better understanding of physiological and pathological processes. This in turn necessitates, among other things, a better grasp of the newer chemistry and physics of today. Mathematics has become a necessity. And when we add that of all people a doctor needs to understand man and his ways, then it is clear that the humanities cannot be neglected. The fact of the matter is that we have not altogether avoided the error of allowing the medical curriculum to grow by accretion and to become congested. It is a matter of interest that 'how to teach?' did not greatly exercise the minds of the teachers of medicine in the days we are speaking of. Today it is a problem recognized to be second in magnitude only to the one already mentioned. The pressing need for studying these two problems has found expression in several international congresses of medical education. The complexity of the difficulties is demonstrated by the failure to evolve a course of study which all could agree on and put into operation. (The fact is that nobody expected that to happen.) The congresses served the useful purpose of making it possible to exchange and discuss views and experiences.

Teaching Systems

There are in existence a variety of teaching systems, each with its own advantages, and some applicable best to the circumstances of their individual centres. It would be naïve to ask: Why not be eclectic and pick out all that is good from the many existing curricula and methods, and then put forward valuable suggestions? It is a matter of the greatest difficulty for an established school with its tried system in operation (and with its own individual merits) to introduce radical changes. There is no university course so intricately complicated and made up of so many parts as the medical course. That is not to say that changes have not been made everywhere. There is no medical school which has not introduced improvements in medical teaching. This certainly applies to our South African schools.

Some suggestions to meet the difficulties of so many parts and so great a content in each, especially of the major disciplines, have been to excise and to eliminate ruthlessly. It has been seriously mooted from certain quarters that because what is needed is education and not instruction, and because it is method that is important and not facts—that in a subject like medicine it is not necessary to teach systematically the cardiovascular system, the central nervous system, etc. but only one of them, and that the method applying to one can stand for all. This is what one educationist has said, and we should all agree: 'Memorizing and reproducing factual data should not be allowed to interfere with the primary need for fostering the critical study of principles and the development of independent thought'. But there are facts to be learned—not all the facts can be worked out from first principles—and there are techniques to be learned, not only in surgery, but also in the ordinary examination of a patient. Most of us will agree that in approaching the patient as a 'whole' the 'parts' should not be neglected; especially not the psychological side of his personality.

Clinical Teaching in South Africa

How have we fared in this respect in South Africa? Clinical teaching has been in existence in the Union for barely 40 years. The pre-clinical sciences and anatomy and physiology had been taught before, and in the best tradition. In clinical teaching we have in South Africa, for obvious reasons, followed broadly the Scottish system of medical education. This, as everyone knows, is in a number of essentials very different from that of the London medical schools. In the best American schools the ratio of staff to students is so favourable that it is possible for the clinical students to be incorporated into the different firms or units, practically as junior interns. The two great merits of a system such as this are that the student has duties and responsibilities and that he is virtually an apprentice. In schools like Harvard each undergraduate engages in a research project. A distinctive aspect of the system which prevails in the London medical schools is the full-time engagement of the student in successive departments. But it can be said without fear of contradiction that more important by far than any specific system is the *attitude* of the teachers and the attitude they inculcate in their students.

There have been fundamental changes in teaching in South African medical schools during the past 40 years. There have been changes in content, changes in methods, and such basic changes as the introduction of research—which was non-existent in the clinical years—and the introduction of postgraduate training on a large scale. With the coming into being of what is called the Joint Scheme (i.e.

joint control of medical education by the university and the Provincial Administration) there has been a manifold increase in teaching staffs, whilst at the same time the size of clinical classes was reduced to manageable proportions. A tutorial class today consists of but half a dozen students. The considerable increase in the full-time staff, the institution of a system of numerous full-time registrars, and the installation of a sizable body of technicians have made research possible.

It will be remembered that at one time, after World War II, there were 160 or more students in each class. A clinical professor (we had 2 in medicine in Cape Town) had no more than one full-time assistant. There were several tutors, but the number of students in the sections allotted to each was far too numerous. The 'honoraries' in charge of the beds were clinical lecturers. It was no fault of theirs, but attributable to the system, that their classes were grossly overcrowded, with too little time allotted for clinical lectures and ward rounds which took place on the same afternoon on which they visited the hospital. These men laboured under great disadvantages. They had no full-time staff other than their recently qualified house physicians. They were assisted in the wards by registrars who held part-time appointments. It says a great deal for the teaching of those days that the results were as good as they were—because good they were. If there was a good deal of memorizing of factual data there was not lacking a properly critical and enquiring attitude of mind. Principles were stressed; independent thought was not crushed. At a time, for instance, when the pharmacopœia contained but a few specific and effective remedies there was as sane an approach to medication as anywhere in the world.

Changes in Teaching Methods

There have been definite changes in teaching methods, the main advances having taken place in the direction of coordination. It cannot be said that we have gone anything like far enough, but there has been a gradual increase in conferences, seminars and small-group teaching activities. There has been talk of getting final-year students attached for periods to practising general practitioners. In the school that I know best the students in their final year of study have each, for periods, what may be looked on as a small practice, i.e. 6 or 8 patients in respect of whom they have, at set periods, the benefit of members of the staff in consultation. The fact that this kind of 'practice' carries no responsibilities must be admitted straight away to be a defect.

A pre-clinical year which is more or less identical with that designed for science students is surely inappropriate. We have attempted practically no integration in the anatomy and physiology courses. The physiology students now get some demonstrations on clinical cases. Pathology is no longer taught as an isolated study. The present system—clearly a better scheme—is so designed that the student, after his introduction to pathology in the third year of study, is able to learn the pathology of the cases he encounters in the wards in which he is working. The staff is not yet large enough for this scheme to have matured.

What must be greatly helpful for the student commencing his clinical studies is the course in introductory medicine. The medical student of not so many years ago had the following confusing initiation. He was confronted with the lectures in medicine which started, understandably, with the fevers, which were nicely rounded-off diseases, of known causation and method of infection, running well-observed clinical courses and having easy methods of diagnosis. At the same time, however, his tutorial began—again for sound reasons—with the cardiovascular system (a field permitting of easy and precise demonstration of physical signs and clinical methods); and his case for clerking could easily have been one of essentially hepatic or renal disease. Today all this is preceded in the second half of the third year of study by an introductory course of medicine consisting of the bare bones of the different groups of disease, with demonstrations. The student is no longer lost when he enters the medical wards. There is also a course of psychology leading to a realistic course of psychiatry. Gone are the days when psychiatry was equated with the psychoses. The value of social medicine is indicated by the presence on the staff of a senior lecturer in that discipline.

Older graduates will probably remember that the only lantern slides ever shown in lectures were those of some endocrine cases. Today no lecture is without its slides—of cases, specimens, graphs, tables, and in colour.

To round off the 6 years of formal training there is today the excellent system of compulsory internship.

THE DURBAN MEDICAL SCHOOL

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Professor of Pathology and Dean of the Faculty of Medicine, University of Natal

The University of Natal, through its Faculty of Medicine, provides a 7-year course of training for undergraduate students for the primary qualification of M.B., Ch.B. Provision is also made for M.Med. degrees for graduates.

Since its inception in 1951, the institution at which the students are trained has been known as the Durban Medical School.

HISTORY

In 1922, the late Dr. J. B. McCord and Dr. Alan B. Taylor (at present a member of the Board of the Faculty of Medicine) started a private school in Durban for the training of African men as medical practitioners. At that time, the authorities responsible for the registration of medical practitioners were not prepared to recognize a qualification inferior to that which was ordinarily required by medical practitioners for registration in the Union of South Africa, and Dr. McCord and Dr. Taylor were obliged to abandon their efforts.

In 1928, the late Prof. J. W. Bews (who became the first Principal of the Natal University College) included the establishment of a Medical School in a programme of University development in Natal. In the same year, the "'Loram' Committee on the Training of Natives in Medicine and Public Health" recommended the establishment in

Johannesburg of a medical school for Natives, segregated from the existing medical school, but under its control.

In 1938, a Government committee appointed to investigate and report on medical training in South Africa concluded 'that the establishment of a separate medical school for non-Europeans in the future be envisaged; for this purpose we think Durban would be the most suitable centre'. The Secretary of this Committee was Dr. E. G. Malherbe, who in 1945 became the Principal of the Natal University College (later the University of Natal).

In January 1944, a meeting was held at the home of Dr. G. G. Campbell (at present Chairman of the Council of the University of Natal), and a small committee was appointed to ensure that Durban should not be overlooked as a centre for medical training. A series of public meetings was convened during 1944 and 1945, in support of the establishment of a medical school in Durban. Towards the end of 1944, the National Health Services Commission, under the Chairmanship of Dr. Henry Gluckman (later Minister of Health in the United Party Government of General Smuts), after considering the claims of Johannesburg as against those of Durban, came to the conclusion that 'the balance of evidence was in favour of Durban as a site of a medical school primarily for non-Europeans, but also for those whose object is to serve non-Europeans'.

A series of representations were made to the Government and, in 1947, General Smuts on behalf of his Cabinet approved, in principle, the establishment of a medical school in Durban under the aegis of the University of Natal.

Early in 1948, a Medical School Committee, which had been established in Natal, met General Smuts in order to enlist his support in expediting the implementation of his Government's decision. He undertook to request Mr. Hofmeyr, the responsible Minister at the time, to make the necessary provisions in such a manner that the medical school should not prove a financial embarrassment to the Natal University College. Soon afterwards, Mr. Hofmeyr died and in the same year the Nationalist Government came into power.

After lengthy negotiations with the Nationalist Government, the late Dr. A. J. Stals (who was both Minister of Health and Minister of Education) announced in 1949 that the Nationalist Government Cabinet had reaffirmed the approval given in principle for the establishment of a Faculty of Medicine in the newly constituted University of Natal.

In 1950, in conveying the decision of the Government to proceed with the establishment of a medical school in Durban under the control of the University of Natal, the Secretary for Education indicated to the University that the Government had agreed to a special subsidy being made available to the University, provided that no European students were enrolled in the Faculty. The Council of the University accepted this condition in respect of *undergraduate students* with the proviso that, subject to the agreement of the Minister of Education, European students might be admitted to the Faculty of Medicine.

Opening of Faculty

In 1950, an Acting Board of the Faculty of Medicine was created and Dr. Alan B. Taylor was appointed Acting Dean of the Faculty.

The Medical School was opened in 1951 with an enrolment of 35 students in the Preliminary Year of study.

In 1952, Dr. Taylor was succeeded by Prof. G. W. Gale, who relinquished his post as Secretary for Health to become full-time Dean of the Faculty. Professor Gale left the service of the University on 30 April 1955.

RELATIONSHIPS WITH THE NATAL PROVINCIAL ADMINISTRATION

The development of the Faculty of Medicine was made possible through the active participation of the Natal Provincial Administration.

Negotiations with the Natal Provincial Administration were initiated soon after the Treasury approval for the establishment of the Faculty was obtained in 1950. These negotiations have been of a highly complex nature and involved the establishment of King Edward VIII Hospital as the teaching hospital of the Faculty.

After several years of negotiation and before the clinical training of the leading group of students had commenced in 1955, a memorandum of agreement was entered into between the Natal Provincial Administration and the University. In terms of this agreement, the Natal Provincial Administration has made substantial financial contributions towards the maintenance and development of the Medical School.

All full-time members of the joint staff of the Natal Provincial Administration and the University of Natal, receive part of their emoluments from the Natal Provincial Administration for their service responsibilities in the hospital. A system of staffing was developed whereby all the part-time visiting staff members to the hospital became teachers at the University. In this way, largely through the cooperation of the Natal Provincial Administration and the part-time staff (most of whom had previously held visiting staff appointments at the hospital), it became possible to provide an integrated and adequate staffiing arrangement which has ensured to the Faculty of Medicine the highest possible standards in clinical training.

In spite of many initial difficulties, a spirit of cooperation and mutual confidence has been developed between the University of Natal and the Natal Provincial Administration, and between the full-time and part-time members of the academic staff.

The academic staff at present serving the University consists of 18 full-time members and 91 part-time and honorary members.

THE DEGREES OF M.B., CH.B.

The 7-year course leading to the degrees of M.B., Ch.B. is open to all matriculated non-European students who have, in addition, passed mathematics at their matriculation examination. The curriculum of training extends over 7 years and the courses are as follows:

Preliminary year: English 1 or Afrikaans 1, History 1, Botany 0, Physics 0, and Chemistry 0.

First year: Chemistry 1, Botany 1, Physics 1, Zoology 1, and Sociology 1.

Second year: Anatomy, Physiology, and Psychology (first part of half course).

Third year: Psychology (second part of half course), Pathology, and Pharmacology.

Fourth, fifth and sixth years: Medicine; Surgery; Obstetrics and Gynaecology; Social, Preventive and Family Medicine; Special subjects.

SPECIAL FEATURES OF THE COURSE OF TRAINING

Reference to the regulations laid down by the South African Medical and Dental Council relating to the 'minimum medical curriculum' shows that students in the University of Natal take in their pre-medical studies (in addition to botany, chemistry, physics and zoology), courses in English (or Afrikaans), history and sociology. In addition, the students are required to take a credit course in psychology during the second and third years. The study of social, preventive and family medicine forms part of the clinical course of training during the 4th — 6th years of the curriculum.

The curriculum structure as outlined shows that in the early years of study disciplines are provided in the humanities and in the sociological sciences, as well as in the physical and biological sciences. This provides an effective background for training in the later years of study when the students are required to undertake clinical studies at the King Edward VIII Hospital as well as in the homes of families in communities served by the Institute of Family and Community Health in Durban.

STUDENTS IN TRAINING

The first group of students qualified in November 1957. A total of 45 graduates (37 male and 8 female) have obtained their M.B., Ch.B. degrees at the University of Natal since November 1957.

The distribution of the students in the various years of study in 1959 was as follows:

Year	*Men*	*Women*	*Total*
Preliminary ..	38	6	44
First	24	5	29
Second	25	8	33
Third	32	1	33
Fourth	14	2	16
Fifth	15	3	18
Sixth	25	5	30
Total ..	173	30	203

There are African, Indian and Coloured students in the Faculty. By an arrangement entered into between the Ministry of External Affairs and the Governments of the Central African Federation and the Protectorates, a limited number of extra-territorial Africans have been admitted to the Faculty of Medicine. In 1959 there were 15 African students from the Central African Federation, 6 from Basutoland, and 1 from Swaziland in the Faculty.

The Department of Education makes 15 bursary/loans available for each year of study for Africans born in the Union of South Africa. These bursary/loans are available for the entire course of study over 7 years.

In the event of there not being sufficient Africans eligible for bursary/loans in a particular year of study, the Department of Education may authorize a single award to a Coloured student and a single award to an Indian student. The South African students come to the Faculty from all parts of the country and the majority of the students gain admission to the preliminary year of study. The University regulations, however, provide that a student who holds an approved degree of any other recognized University and who has obtained credits in botany, chemistry, physics and zoology, may be permitted to enter direct upon the work of the second year of the curriculum. A number of students holding B.Sc. or B.Sc. (Hygiene) degrees, mainly from the University College of Fort Hare, have been admitted to the second year of study. Apart from the State bursary/loans there are a limited number of private bursary/loans and small bursaries and scholarships.

Selection of Students

Normally there are many more qualified applicants for admission to the Faculty than there are places available.

Research into the problems regarding the selection of students has been in progress for the past 4 years, with particular reference to the prediction of pre-medical and pre-clinical examination results. The Faculty's procedure for the selection of students now includes personal interviews and written tests of intelligence and special abilities.

DEPARTMENTAL ACTIVITIES

Detailed information relating to the activities of the departments in the Faculty show that great developments have taken place in the Medical School under the aegis of the University of Natal. These developments have occurred not only in teaching but also in the field of research. Grants in support of research have been received from organizations such as the South African Council for Scientific and Industrial Research, the National Cancer Association of South Africa, the Schlesinger Organization, the Rockefeller Foundation, the National Institutes of Health of the United States, and several other bodies and private individuals.

CONCLUSION

There is little doubt that the establishment of a Faculty of Medicine within the University of Natal has been one of the most significant events in medicine in South Africa. Apart from the training of non-White medical practitioners for service in the country, members of the staff of the Faculty have, in a few years, made most valuable contributions to research and to the advancement of medical knowledge.

FORTHCOMING INTERNATIONAL MEDICAL CONFERENCES

Humboldt-Universität zu Berlin, Medizinische Fakultät (Charité). The celebration of the 250th aniversary of the Charité will be held in Berlin from 6 to 19 November 1960 in connection with the 150th anniversary of the Humboldt University. Applications for participation are to be directed to the Committee for the Preparation of the 250th Anniversary of the Charité, Schumannstrasse 20-21, Berlin N 4, Germany, c/o Dozent Dr. med. habil. Dagobert Müller, Secretary of the Committee.

The Seventh International Congress of Hydatidology will be held in Rome on 15-17 September 1960 and Sassari on 18-19 September. Delegates from the Union of South Africa will be welcome to attend this Congress, which will deal with various aspects of hydatidosis. Further information may be obtained from the President of the Congress, Prof. P. Valdoni, Clinica Chirurgica, Policlinico Umberto 10, Rome.

South African Medical Journal : Suid-Afrikaanse Tydskrif vir Geneeskunde

EDITORIAL : VAN DIE REDAKSIE

FIFTY YEARS OF MEDICINE IN SOUTH AFRICA

It is an interesting fact that Jan van Riebeeck, who landed at the Cape on 6 April 1652 as the founder of the first European settlement in South Africa, was by profession a ship's surgeon. This event foreshadowed the course that medical history in South Africa was to take during the next two-and-a-half centuries. Throughout this period the inhabitants of this part of the continent were entirely dependent on medical doctors who had received their professional training elsewhere in the world.

The first institution South of the Sahara where some degree of medical training was undertaken, was established in Madagascar in 1896, as pointed out by Professor Snyman on page 422 of this issue. It was, however, only after the establishment of the medical faculty at the University of Cape Town in 1918 that facilities were created for the complete and independent training of doctors in Southern Africa. Other medical schools in different parts of the continent were subsequently established as follows: Witwaterstand in 1921, Makerere in 1924, Khartoum in 1924, Pretoria twenty years later in 1943, Nigeria in 1948, Dakar in 1950, Durban in 1951, Lovanium (Leopoldville) in 1954, Stellenbosch in 1955, and Elizabethville in 1956. Today more than 70% of all practising doctors in South Africa have qualified at one of the South African medical schools. Furthermore, medical training in this country is now being conducted in both official languages. The festival celebrations, after fifty years of Union, provide an appropriate opportunity to review some of the more important aspects of medical professional life in this country.

Undergraduate medical training. Although we are still devising ways and means of developing the best possible system of training for undergraduate students, as both Professor Forman and Professor Snyman point out on pp. 413 and 422 of this issue, we can confidently state that medical training in this country compares favourably with that provided in any other part of the world. The truth of this statement is proved by the fact that students who qualify at our South African universities achieve excellent results when they go to medical schools overseas for postgraduate study.

It should further be mentioned that we have succeeded in developing a dignified and dependable system of general practice in which the general practitioner still remains a key figure. As we pointed out recently[1] there is maldistribution of doctors in South Africa in respect of the ratio of specialists to general practitioners and the ratio of doctors practising in rural and those in urban areas. In spite of this we still find many responsible general practitioners who practise medicine on the highest level, who are independent, and who are able to manage and treat most serious illnesses successfully.

Postgraduate study and research. Facilities for postgraduate training are available at all the medical schools in the country. These facilities are important in the training of specialists and also in the schooling of research workers. The whole problem of medical research, as described by Professor Brock on p. 420 of this issue, was greatly facilitated by the establishment and development of the South African Institute for Medical Research since 1912. It can be said without hesitation that the research carried out at this Institute has reached a very high standard indeed.

Additional support for research projects is derived from financial aid made available to universities and other institutions by organizations such as the Council for Scientific and Industrial Research and the National Nutrition Research Institute, on the one hand and, on the other hand, from the system of research units which have developed in the various departments of our medical faculties. These research units have come into being as the result of the imaginative and far-sighted leadership of some of the senior members of the teaching staffs at our medical schools. Research work on a high level is being carried out by these special units. Examples of such work are the research carried out in connection with open-heart surgery, the artificial kidney, the compression suit used in confinements, the revolutionary new artificial limb, special surgical procedures, and research in nutrition, heart disease, and metabolic and endocrine conditions, etc.

The existing facilities for research at various universities to which we have just referred have, since 1950, received an additional incentive from the establishment of a system of joint medical services. Professor Brock describes this system on p. 420 of this issue and points out that the most significant effect of this new system has been that men of high academic achievement and research potential are more frequently being attracted into full-time appointments. There they can devote themselves to the raising of standards and the advance of knowledge without the inevitable distractions of private practice. A real partnership between full-time and part-time staff has developed and brings mutual benefit.

The College of Physicians, Surgeons and Gynaecologists of South Africa. A review of the facilities for postgraduate study and research in this country is incomplete without a consideration of the part played by the College. The idea of a South African College, on the lines of the Colleges in other countries, arose during World War II, and the necessity for a College became apparent after the War when conditions and circumstances made it difficult, if not impossible, for South African medical practitioners to obtain higher qualifications overseas. A Steering Committee, which was appointed to manage the affairs of the College, remained in office until it had carried out the mandate it had received from the Inaugural Meeting to amend the constitution, and, after enrolling four hundred Founders, it handed over the management of the College to the first elected Council at the First Annual General Meeting of the College of Physicians, Surgeons and Gynaecologists of South Africa in August 1956.

The first examinations were held on 30 September 1957, and consisted of the following: Fellowship of the College of Physicians of South Africa, F.C.P.(S.A.); Part I of the Fellowship of the College of Surgeons of South Africa, F.C.S.(S.A.); Fellowship of the College of Obstetricians

and Gynaecologists of South Africa, F.C.O.G.(S.A.); and the Diploma in Midwifery of the College of Obstetricians and Gynaecologists of South Africa, Dip.Mid. C.O.G.(S.A.). The College has progressed since those early days and now conducts ten examinations twice a year, including those listed above. The undermentioned degrees and diploma have been approved since then by the South African Medical and Dental Council for registration in the Specialist Register: Fellowship of the College of Physicians of South Africa, with Psychiatry; Fellowship of the College of Physicians of South Africa, with Neurology; Fellowship of the Faculty of Anaesthetists of the College of Physicians, Surgeons and Gynaecologists of South Africa, F.F.A.(S.A.); and the Diploma in Psychiatric Medicine of the College of Physicians of South Africa. Since the first examinations were held in 1957, one hundred and fifty-one candidates have written the College examinations; fifty-seven of them were successful, of whom twenty-four obtained their Fellowships. The membership of the College totals six hundred and eighty-three, consisting of Founders, Associate Founders, Fellows, Honorary Fellows and Diplomates, and in the words of the President of the College, Prof. G. A. Elliot, 'The College of Physicians, Surgeons and Gynaecologists of South Africa is essentially a unity of members with diverse professional interests, but all with the single purpose of furthering the progress of and promoting medical practice in South Africa'.

The South African Medical and Dental Council is a body which fulfils an important function in the medical professional life in South Africa. The members of this Council consist of representatives appointed by the Government, the universities, and the Nursing Council to represent the various universities, the Department of Health, and the dental, nursing and legal professions; and of representatives elected by all members of the medical and dental professions. The Council is a statutory body entrusted with the task of laying down criteria for the training of medical students, supervising ethical behaviour of doctors, and enforcing disciplinary measures in cases where the ethical rules of conduct have been violated. This Council is held in high esteem throughout the country and is an important link between the medical profession, the Government and the public.

The Medical Association of South Africa is a voluntary professional association of doctors and its aim is to promote the cultural, scientific and financial interests of its members. The great majority of doctors in the country are members of this Association. The rôle played by the Medical Association in the past and its ideals for the future are fully described on p. 423 of this issue by Dr. J. H. Struthers, the present Chairman of the Federal Council.

In reviewing the history of medicine in South Africa it cannot be denied that there are still many defects and shortcomings in the services that are being rendered. There is, however, no doubt that doctors on the whole have the earnest desire to contribute on a creative level to the development of a truly satisfying system of medical services in our country. As in other spheres, so too in the field of medicine, the continent of Africa offers unparalleled opportunities for research and for service. These opportunities should be regarded not only as *opportunities* but also a *challenge* to the medical profession to make a constructive and lasting contribution to the health and well-being of the many nations living on this continent.

In recent times the intensified economic struggle for existence, which has become apparent all over the world, has called disruptive forces into being. As elsewhere, these forces have threatened to undermine the status of the medical profession. It is therefore imperative that all practising doctors should do everything in their power to prevent the commercialization of a profession that has always been inspired by altruistic ideals and the principles of humanity and service. It is indeed a happy thought that in this respect the great body of the medical profession has remained as sound as ever. There have always been and there will always be those 'seven thousand which have not bowed unto Baal' and who, at all times and in all circumstances, will uphold the established traditions and the honour of the medical profession.

1. Editorial (1960): S. Afr. Med. J., 34, 315.

GENEESKUNDE IN SUID-AFRIKA OOR DIE AFGELOPE VYFTIG JAAR

Jan van Riebeeck, wat op 6 April 1652 die eerste keer aan wal gestap het in Kaapstad, was nie net die leier van die eerste Blanke volksplanting nie, maar ook, omrede van sy geskiedkundige omlysting, 'n beroemde skeepsdokter. Hierdie gebeurtenis het op 'n heel besondere manier 'n simboliese voorafskaduwing gevorm van die verloop van die mediese geskiedenis in Suidelike Afrika oor 'n tydperk van meer as twee eeue, want gedurende al hierdie tyd moes almal in dié deel van die vasteland van Afrika afhanklik bly van mediese dokters wat hul skoling en voorbereiding elders in die wêreld gehad het.

Soos professor Snyman op p. 422 van hierdie uitgawe aantoon, het die eerste skemering van 'n eie geneeskundige skoling suid van die Sahara eers in 1896 deurgebreek met die ontstaan van 'n geneeskundige hulp-skool in Madagaskar. Pas egter met die stigting van die geneeskundige fakulteit aan die Universiteit van Kaapstad in 1918, het die eerste werklik eie en volwaardige opleiding in Suid-Afrika en in Suidelike Afrika ontstaan. Die ander geneeskundige skole, wat soos volg oor die vasteland versprei is, het daarna gevolg: Witwatersrand in 1921, Makerere in 1924, Khartoem in 1924, Pretoria twintig jaar later in 1943, Nigerië in 1948, Dakar in 1950, Durban in 1951, Lovanium (Leopoldstad) in 1954, Stellenbosch in 1955, en Elizabethstad in 1956. Vandag is die toestand van sake só dat meer as 70% van alle praktiserende geneeshere in Suid-Afrika aan een van die Suid-Afrikaanse geneeskundige skole gekwalifiseer het en dat mediese opleiding nou in albei landstale moontlik is. By die geleentheid van die vyftigjarige herdenking van die totstandkoming van die Unie, sal dit dus goed wees om 'n kort perspektiewe blik te werp op die verskillende fasette van die geneeskundige beroepslewe in ons land.

Voorgraadse studie. Alhoewel ons nog steeds, soos professors Forman en Snyman aantoon op pp. 413 en 422 van hierdie uitgawe, besig is om planne en metodes te ontwerp op grond waarvan die beste en voordeligste opleiding aan voorgraadse studente gegee kan word, kan ons tog sê dat

ons mediese opleiding gunstig vergelyk met dié wat op enige ander plek in die wêreld beskikbaar is. Ons sê dit aangesien ons weet dat die studente wat aan ons Suid-Afrikaanse Universiteite afstudeer uitstekend vaar wanneer hulle vir nagraadse studie na die buitelandse mediese skole gaan.

Ook moet ons daarop wys dat ons daarin geslaag het om 'n waardige en betroubare stelsel van algemene praktyk op te bou waarin die algemene praktisyn tog nog 'n sleutelfiguur is. Soos ons onlangs aangetoon het, bestaan daar wel in Suid-Afrika 'n wanverdeling van dokters wat betref die verhouding tussen spesialiste en algemene praktisyns, en ook wat betref die verhouding tussen die aantal stedelike en plattelandse geneeshere.[1] Maar ten spyte hiervan het ons nog orals in die land verantwoordelike algemene praktisyns wat die beste soort praktyk beoefen, wat onafhanklik is, en wat in staat is om ook die meeste ernstige siektetoestande met sukses te hanteer.

Nagraadse studie en navorsing. Nagraadse studiegeleenthede bestaan aan al die mediese skole in die land en hierdie geleenthede vorm 'n belangrike faset van die voorbereiding van spesialiste en ook van die kweking van navorsers self.

Die hele probleem van mediese navorsing, soos professor Brock op p. 420 van hierdie uitgawe aantoon, het 'n groot stoot vorentoe gekry met die stigting en uitbouing van die Suid-Afrikaanse Instituut vir Mediese Navorsing sedert 1912; en daar bestaan geen twyfel nie dat ons met trots kan verwys na die omvang en standaard van mediese navorsing wat daar aan hierdie Instituut gedoen word.

Bykomstige stukrag vir navorsing word enersyds verkry uit die geldelike ondersteuning wat aan Universiteite en ander inrigtings beskikbaar gestel word deur liggame soos die Wetenskaplike Nywerheids- en Navorsingsraad en die Nasionale Instituut vir Navorsing oor Voedingsprobleme, en andersyds uit die stelsel van navorsingseenhede wat daar in die verskillende departemente van ons geneeskundige skole ontstaan het. Dit is as gevolg van die verbeeldingryke en visionêre leiding van sommige senior lede van die doserende personeel aan ons mediese skole dat hierdie navorsingseenhede ontstaan het, en dat navorsingswerk op die hoogste vlak moontlik geword het. Ons dink hier byvoorbeeld aan werk in verband met oop hartchirurgie, die kunsnier, die kompressiepak by bevallings, die revolusionêre nuwe kunsbeen, spesiale snykundige prosedures, en navorsingswerk oor voeding, hartsiektes, en metaboliese en endokrientoestande, ens.

Die bestaande navorsingsgeleenthede aan die verskillende universiteite waarna ons nou net verwys het, het sedert 1950 'n verdere impetus gekry met die instelling van die stelsel van gesamentlike mediese dienste. Professor Brock beskryf dié stelsel op p. 420 van hierdie uitgawe en toon onder andere aan dat die mees betekenisvolle gevolge van dié stelsel dit is dat meer en meer persone met hoë akademiese kwalifikasies en 'n belangstelling in navorsing na voltydse hospitaalbetrekkings gelok word. Hulle kan dan hul volle aandag aan die uitbreiding van kennis bestee sonder die onvermydelike hindernisse wat die private praktyk op hierdie gebied teweegbring.

Die Kollege van Interniste, Chirurge en Ginekoloë van Suid-Afrika. 'n Oorsig van die fasiliteite vir nagraadse studie en navorsing in hierdie land is nie volledig as die rol van die Kollege nie vermeld word nie. Die idee van 'n Suid-Afrikaanse Kollege, op die grondslag van oorsese Kolleges, het gedurende die Tweede Wêreldoorlog ontstaan. Die noodsaaklikheid van so 'n Kollege het na die oorlog duidelik geword toe omstandighede dit moeilik en selfs onmoontlik gemaak het vir Suid-Afrikaanse praktisyns om hoër kwalifikasies te verkry. 'n Reëlingskomitee wat saamgestel is om leiding te neem in die sake van die Kollege, het in beheer gebly totdat die mandaat van die Inwydingsvergadering uitgevoer is, nl. om die grondwet op te stel. Nadat vierhonderd stigterslede gewerf is, is die bestuur van die Kollege aan die eerste verkose Raad oorhandig tydens die eerste Jaarlikse Algemene Vergadering van die Kollege van Interniste, Chirurge en Ginekoloë, in Augustus 1956.

Die eerste eksamens is op 30 September 1957 afgeneem, en het bestaan uit: Lidmaatskap van die Kollege van Interniste van Suid-Afrika, L.K.I.(S.A.); Deel I van die Lidmaatskap van die Kollege van Chirurge van Suid-Afrika, L.K.C.(S.A.); Lidmaatskap van die Kollege van Obstetrici en Ginekoloë van Suid-Afrika, L.K.O.G.(S.A.); en die Diploma in Verloskunde van die Kollege van Obstetrici en Ginekoloë van Suid-Afrika, Dip. Ver. K.O.G.(S.A.).

Die Kollege het gegroei sedert daardie vroeë dae en tien eksamens word nou twee keer per jaar afgeneem. Die volgende grade en diploma is sedertdien deur die Mediese Raad goedgekeur as kwalifikasies wat geregistreer kan word met die oog op die Register vir Spesialiste: Lidmaatskap van die Kollege van Interniste van Suid-Afrika met Psigiatrie; Lidmaatskap van die Kollege van Interniste van Suid-Afrika met Neurologie; Lidmaatskap van die Fakulteit van Anestesioloë van die Kollege van Interniste, Chirurge en Ginekoloë van Suid-Afrika; en die Diploma in Psigiatriese Medisyne van die Kollege van Interniste van Suid-Afrika.

Sedert die eerste eksamens in 1957 afgeneem is, het honderd een-en-vyftig kandidate deelgeneem aan die eksamens van die Kollege; sewe-en-vyftig van hulle was suksesvol, waarvan vier-en-twintig 'n Lidmaatskap verwerf het. Die totale ledetal van die Kollege is nou ses honderd drie-en-vyftig, bestaande uit Stigters, Medestigters, Lede, Ere-lede en Diplomate. In die woorde van prof. G. A. Elliott, President van die Kollege, is ‚Die Kollege van Interniste, Chirurge en Ginekoloë van Suid-Afrika wesentlik 'n eenheid van lede met uiteenlopende professionele belange, maar wat almal tog een en dieselfde doel het, om die mediese praktyk in Suid-Afrika uit te bou en te ondersteun'.

Die S.A. Geneeskundige en Tandheelkundige Raad is 'n liggaam wat 'n belangrike rol speel in die mediese professionele beroepslewe in Suid-Afrika. Die lede van die Raad bestaan uit verteenwoordigers wat deur die Regering, die universiteite en die Verpleegstersraad aangestel word om die verskillende universiteite, die gesondheidsdepartement, en die tandheelkundige-, verplegings- en regsprofessies te verteenwoordig, en uit verteenwoordigers wat gekies word deur alle lede van die mediese professie. Die Raad self is 'n statutêre liggaam wat veral belas is met die opstel en handhawing van maatstawwe vir mediese opleiding, die toesig oor etiese gedrag, en die uitvoering van dissiplinêre magte in gevalle waar etiese gedragsreëls oortree word. Hierdie Raad het 'n hoë aansien in die land en dien veral as 'n skakel tussen die mediese professie, die Regering en die publiek.

Die Mediese Vereniging van Suid-Afrika is 'n vrywillige beroepsvereniging van dokters wat dit vir hom ten doel stel om die kulturele en wetenskaplike en finansiële belange van sy lede te bevorder. Verreweg die meeste dokters in die land behoort aan die hierdie Vereniging. Die rol wat die Mediese Vereniging in die verlede gespeel het en sy ideale vir die toekoms word uiteengesit op p. 423 van hierdie uitgawe deur dr. Struthers, die huidige voorsitter van die Federale Raad van die Mediese Vereniging.

As ons die geskiedenis van die medisyne in Suid-Afrika in perspektiewe oënskou neem, moet ons toegee dat daar wel nog baie leemtes en tekortkominge is. Daar is egter ook die wil en begeerte by die meeste dokters om op 'n skeppende wyse voort te gaan met die opbou van 'n stelsel van mediese dienste wat die land van ons tuiste op die beste manier sal kan dien. Ook op die gebied van die medisyne bied Afrika ongeëwenaarde geleenthede vir navorsing en vir diens. Hierdie geleenthede moet aanvaar word nie net as geleenthede nie, maar ook as 'n uitdaging.

Soos ook in ander dele van die wêreld het baie ontwrigtende kragte in die jongste tyd op ons as 'n professie ingewerk as gevolg van die spanning en drukte wat saamhang met die versnelde en verhewigde pas van die ekonomiese stryd om te bestaan. Ons moet dus doelbewus waak teen die kommersialisering van 'n beroep wat nog altyd op idealistiese grondslag gerus het. Gelukkig kan ons sonder die minste twyfel verklaar dat die mediese professie oor die algemeen ook op hierdie gebied gesond en produktief is. Daar was nog altyd en daar is nog steeds die so noodsaaklike en belangrike kern van ‚sewe duisend wat nie die knie voor Baäl gebuig het nie' en wat onder alle omstandighede die eeuoue tradisies en die eer van die mediese professie sal handhaaf.

1. Van die Redaksie (1960): S. Afr. T. Geneesk., **34**, 315.

THE EVOLUTION OF MEDICAL RESEARCH IN SOUTH AFRICA

J. F. BROCK, D.M., F.R.C.P., *Professor of Medicine, University of Cape Town*

Until the founding of the South African Institute for Medical Research in 1912 there was very little, if any, organized scientific investigation of the medical problems of the country. There always were, of course, individual doctors in whom the itch to know 'how and why' overcame all obstacles, including the absence of facilities, and led to interesting and original observations and studies. Some of these are recorded in Burrows' *History of Medicine in South Africa*.[1]

Milestones

Among the milestones in the development of medical research in South Africa are the following:

Dr. Alexander Edington started work at the Colonial Bacteriological Institute in Grahamstown in 1891 and made important contributions to the study of horse-sickness. In 1897 the Natal Government opened the Allerton Veterinary Laboratory for bacteriological research. This development followed the work of Surgeon Major (later Sir) David Bruce who demonstrated the trypanosomal origin of the epidemics of *nagana* which occurred in Zululand between 1894 and 1897. Other famous bacteriologist visitors to South Africa included Koch who worked on rinderpest in Kimberley in 1896 and Bordet and Danysz who visited Dr. A. Theiler in the Transvaal at about the same time.

Organized veterinary research was greatly encouraged by the founding of the Veterinary Research Institute at Onderstepoort in 1908. The first director Dr. (later Sir) Arnold Theiler had been appointed by the Transvaal Republican Government in 1893 as veterinary officer and gave invaluable service in the rinderpest epidemic of 1896 - 8.

Owing to its obvious economic implications there was at first a tendency for veterinary research to be more strongly encouraged than medical research. This lack of balance began to be reversed with the founding of the *South African Institute for Medical Research* in 1912. Its first director, Watkins-Pitchford, had come to South Africa as a British military bacteriologist in 1900 after having served as a plague officer in India.

The origins of the Institute were described by Cluver[2] in 1944. It arose from the need for investigation of diseases such as silicosis and pneumonia—another example of the effect of economic forces on medical science. Its purposes were defined as: (1) Researches and investigations into the causes and methods of prevention of human diseases; (2) laboratory examinations of a diagnostic nature for health authorities, hospitals, the mining industry and others; and (3) the preparation of biological products for the prevention and treatment of diseases, including vaccines, antitoxins, antibacterial sera and similar products (*South African Year Book*).

The Institute has a proud record of achievement in medical research. Dr. James Gear, an eminent South African virologist, has just succeeded to the directorship.

But however brilliantly the Institute might have tackled the problems of medical research in South Africa, its contribution must have remained limited were it not for the awakening of the research spirit in the medical schools.

The first medical school in the country was established in Cape Town in 1918 and Dr. Simpson Wells[3] in his article on 'Medicine in the Cape in the early days of the century' traced some of the early scientific work which led up to it.

A medical school which is not continuously engaged in an active and imaginative programme of research is dead, will not advance, and will probably deteriorate in its general standards and efficiency. One need only cast back one's thoughts to the sterility and credulity of medical practice in the 17th century, before the advent of the great experimentalists such as Harvey and Claude Bernard, to picture what a modern medical school would be like without research, and how the standards of medical practice in the community would deteriorate. The spirit of controlled scientific enquiry is a leaven which permeates every activity of a department of medicine, and without it the resultant bread is flat. It is easy to argue that the main function, at least of an undergraduate medical school, is the training of medical practitioners, and that research is therefore not a strictly necessary activity. This facile argument is at first not easy to answer, but the answer is very definite when it is found, and is fundamental to the whole spirit of university

education. Teaching and training which are not continually enriched by the leaven of research become flat and unimaginative and eventually fixed in outmoded concepts. Even the worst undergraduate medical school must have a small number of students in whose blood the research spirit runs actively. They are likely to be the intellectual leaders of the medical school and without stimulus and example of research among their teachers, their promise will be aborted.

DEVELOPMENTS IN MEDICAL SCHOOLS

In the light of these principles the developments in our medical schools since the end of the Second World War are distinctly encouraging. The progress made can, in my opinion, be attributed in considerable part to two administrative developments:

1. *The South African Council for Scientific and Industrial Research*

This Council was established after the last war, through the wisdom of the late Field Marshall J. C. Smuts.

Under its first President, Dr. B. J. Schonland, the Council soon set up a Medical and Dental Research Committee. The early work of this Committee was reviewed in 1948 by its first Chairman, Prof. S. F. Oosthuizen,[4] who has himself played a significant and valuable part both in early planning and in later development.

The effect that this organization has had on research in general and particularly on medical research over the last decade is quite incalculable. For the first time it became possible to obtain money for apparatus and equipment and for the payment of research technicians. The Council's policy from an early stage was to encourage fundamental and applied research equally, and particularly to look for and support those men who were active in research in spite of the lack of facilities. As part of this policy the Medical Units were set up.

In his review Oosthuizen refers to the establishment of liaison officers abroad, financial support for the South African Institute for Medical Research, and to the establishment of an applied Physiology Research Unit to cater for the medical needs of the mining industry. But nothing was more significant for progress than the proposal to set up Medical Units in the medical schools. This policy has been most fruitful. The 8 units originally envisaged has now become 14.[5]

The extent of financial support will need to be steadily increased if the growing research potential of the medical schools is to be developed. University medical research in South Africa has been fortunate in escaping the drift to centralization of research in CSIR institutes in Pretoria which has occurred in the pure and applied physical sciences. These institutes serve a valuable function, but if they result in the starving of university research training they will soon become sterile seats of uninspired repetition. Until the South African Government gives more liberally to research, the University departments will continue to be starved in the physical sciences.

2. *The Joint Medical Services*

Since 1950 the Provincial Administrations, which are responsible for hospitalization, have entered into agreements with the universities to staff the teaching hospitals on a basis of partnership. The honorary system of medical staffing of the teaching hospitals has been replaced by salaried officers. These are engaged full-time, part-time or on a sessional basis. The clinical professors appointed by the Universities nominate for appointments and are responsible for allocation of duties and general integration and maintenance of standards. The most significant effect of this new system has been that men of high academic achievement and research potential are more frequently being attracted into full-time appointments. There they can devote their thinking to the raising of standards and the advance of knowledge without the inevitable distractions of private practice. A real partnership between full-time and part-time staff has developed and brings mutual benefit. The influence of the part-time men prevents any tendency to ivory-tower outlook and keeps the real and total needs of the patient in the forefront of attention. The presence of full-time men, who are productive in research, constitutes a continual challenge to replace outworn concepts by new ideas. The joint effect on standards of medical practice has been remarkable; a glance at the programmes of the last few Medical Congresses will show the fertilizing effect of new ideas.

THE NATIONAL NUTRITION RESEARCH INSTITUTE

Problems of human nutrition are at the forefront of medical attention in South Africa. Four medical research units are built around such problems. The need became apparent for a central institute or laboratory to ensure an integrated and comprehensive approach to the problems of malnutrition and to assist the Government in the application of remedies and prevention. Within a few years of its inception, and with an impressive list of achievements, the National Nutrition Research Institute has now been housed in a fine building on the new site of its parent organization, the Council for Scientific and Industrial Research outside Pretoria. There is no doubt that this Institute will bring an advance in the application of knowledge in the field of nutrition. This in turn will remove one of the most potent causes of ill-health among the underprivileged sections of all racial groups in the country.

THE ADMINISTRATION OF MEDICAL RESEARCH IN SOUTH AFRICA

This important subject was fully investigated by a committee under the chairmanship of Dr. P. J. du Toit, a Vice-President of CSIR, and a former director of the Veterinary Research Institute at Onderstepoort. The Government has not yet declared its policy in regard to this interesting report; on this policy may depend the future health of our medical research productivity.

REFERENCES

1. Burrows, E. H. (1958): *A History of Medicine in South Africa.* Cape Town: A. A. Balkema.
2. Cluver, E. H. (1944): Proc. Transv. Mine Med. Offrs. Assoc., **24**, 39.
3. Wells, A. S. (1954): S. Afr. Med. J., **28**, 934.
4. Oosthuizen, S. F. (1948): S. Afr. Med. J., **22**, 647.
5. South African Council for Scientific and Industrial Research (1958): Thirteenth Annual Report. Pretoria, 1957-1958. Pietermaritzburg: *The Natal Witness.*

DIE OPKOMS EN DIE BYDRAE VAN DIE AFRIKAANSE GENEESKUNDIGE FAKULTEITE

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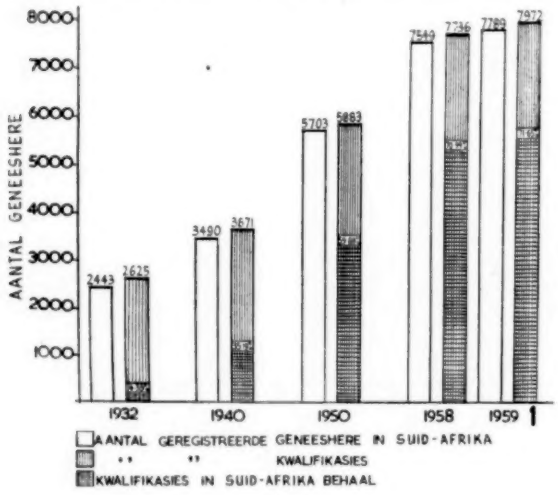
Die reeds welbekende mediese figure van die tonele in Burrows[1] se *History of Medicine in South Africa* moes uiteraard hul skoling in oorsese geneeskundige fakulteite ontvang. So het die eerste Kaapgebore medikus, Le Seuer, sy opleiding in Groningen (1770) en die volgende groep dit in Leiden gekry.

Afrika as geheel moes eeue lank staatmaak op geneeshere met 'n ondernemingsgees en 'n sin vir die vreemde, of wat begeester was met 'n sending om die broodnodige geneeskundige versorging geleidelik beskikbaar te stel. Die eerste skemering van 'n eie geneeskundige skoling suid van die Sahara breek in 1896 deur met die ontstaan van 'n geneeskundige hulp-skool in Madagaskar. Pas egter met die stigting van die geneeskundige fakulteit aan die Universiteit van Kaapstad in 1918 het die eerste werklik eie en volwaardige opleiding in Suid-Afrika en in Afrika suid van die Sahara ontstaan. Ander geneeskundige kersies word egter ook oor die ligter en donker vasteland aangesteek: Witwatersrand in 1921, Makerere in 1924, Khartoem in 1924, Pretoria 20 jaar later in 1943, Nigerië in 1948, Dakar in 1950, Durban in 1951, Lovanium (Leopoldstad) in 1954, Stellenbosch in 1955, en Elizabethstad in 1956. Wat ons eie land betref, word sy

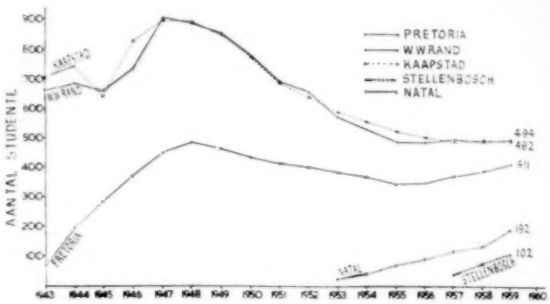


Afb. 1

mediese aanwas en voorsiening en geneeskundige ryping in groot trekke in die syfers[2] weerspieël wat in Afb. 1 aangegee word.

GENEESKUNDIGE ONDERRIG IN AFRIKAANS

Geneeskundige onderrig in Afrikaans het laat op ons toneel verskyn en is nie sonder moeite en pyn verkry nie. In die onweersjare 1938 en 1939 is die gedagte aan 'n Afrikaanstalige mediese skool aan die owerhede vir oorweging voorgelê. Gebrek aan geld en heftige gevoelens in die oorlogsklimaat het botsende strominge in die openbare lewe, op politieke en kerklike terrein, in die pers, en op die akademiese vlak meegebring. In 1943 is die eerste Afrikaanse geneeskundige fakulteit amptelik aan die Universiteit van Pretoria ingestel[3] en gekoppel aan die Algemene-Hospitaal, Pretoria, waar ongeveer 450 Blanke- en 650 Bantoe-beddens vir die onderwys beskikbaar was. In hierdie moeilike eerste jare het die bestendige hand van die eerste dekaan, prof. L. J. te Groen, vastigheid en rigting gegee. Aan belangstelling van die studentekant het dit van meet-af nie ontbreek nie soos blyk uit Afb. 2.[2] Eerder was daar kommer om geskikte personeel



Afb. 2 Aantal geregistreerde mediese studente tot vandag aan die 5 geneeskundige fakulteite in Suid-Afrika. 2

te verkry. Die personeel immers moes nie alleen vakkundig voldoende geskool wees nie, maar moes professionele spanwerk openbaar, met 'n akademiese gees besiel wees of word, en die onderrig in Afrikaans met oortuiging kon oordra. Die moeilike wordingsjare het plek gemaak vir ruimer groeijare en tans reeds kan hierdie fakulteit sy geledere uit sy eie geskooldes en akademies-presterendes aanvul en versterk. Die bydrae van die Fakulteit Geneeskunde van die Universiteit van Pretoria op die nagraadse vlak word in Tabelle I en II aangegee. In Tabel I word die totale aantal nagraadse studente

TABEL I. TOTALE AANTAL NAGRAADSE STUDENTE

Jaar	*Aantal*
1946	1
1947	14
1948	20
1949	33
1950	44
1951	34
1952	55
1953	60
1954	67
1955	69
1956	69
1957	73
1958	75
1959	77

TABEL II. AANTAL GRADE EN DIPLOMAS TOEGEKEN

Grade en diplomas	*Aantal*
1. Baccalaureusgrade:	
M.B., Ch.B.	944
2. Magistersgrade:	
Ch. M. tot 1956	11
M.Med. 1952 - 59	61
3. Doktorsgrade:	
M.D. Klinies	5
M.D.	33
4. Nagraadse Diplomas	36
Totaal	1,090

aangegee, en in Tabel II die totale aantal grade en diplomas wat gedurende die tydperk 1946 - 1959 toegeken is.

Die eerste Afrikaanse fakulteit kon ook 'n bydrae lewer tot die personeel van die tweede Afrikaanse fakulteit wat in 1955 aan die Universiteit van Stellenbosch gestig is. In 'n gunstiger klimaat gekonsipieer, polities en finansieel, het die totstandkoming van dié fakulteit sonder groot woelinge en

diepgaande verskille plaasgevind. Wel is aanvanklik oorweeg of 'n tweede Afrikaanstalige fakulteit nie in Bloemfontein aan die Universiteit van die Vrystaat gestig moes word nie. Die beskikbaarstelling van die nuwe Karl Bremer-Hospitaal met 250 beddens te Bellville het egter kliniese huisvesting vir Stellenbosch meegebring en die onderneming vlot laat loods met prof. F. D. du T. van Zijl as eerste dekaan. Ook hier het personeeltekort in sommige basiese vakke, 'n tekort eie aan die hele land, aanvanklik stremmend gewerk. Die eerste groep geneeshere van hierdie fakulteit sal aan die einde van 1961 afstudeer; die eerste nagraadse studente voltooi ook reeds hul opleiding.

Die stelsel van onderrig wat destyds vir Pretoria oorweeg is, het heelwat gedagtes gaande gemaak. Oor die algemeen is die huidige onderwyspatroon van ons verskeie skole baie naverwant, ten dele uit hoofde van die feit dat 'n gemeenskaplike minimum-leerplan deur die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad neergelê is. Gedurende die vormingsjare van geneeskundige onderwys in Suid-Afrika, 1925 - 1928,[4] was die invloed van die Edinburgse Skool toonaangewend, 'n skool wat op sy beurt deur die Leidense Skool bevrug is. In die tyd van Boerhaave immers het baie van die later toonaangewende Edinburgse klinici hul skoling in Leiden ontvang. Langs hierdie omweg het die Nederlandse invloed ook by ons 'n rol gespeel, aangesterk deur personeellede wat hul studiejare in Nederland deurgebring het. Nog steeds kerf ons skole aan 'n onderwyspatroon wat die beste geneeshere vir ons eie omstandighede sal help kweek.[5]

Afrikaans as Mediese Vaktaal

In hierdie kort oorsig oor Afrikaanstalige geneeskundige akulteite, word die gebruik van Afrikaans as mediese taalmedium as 'n inherente en grondliggende faktor beskou. Ook hierin moes die pioniers helderheid soek en tot gemeenskaplike benadering kom. Die eerste jare het aan die ou stryd tussen Afrikaans en Hollands herinner. Daar was natuurlik geen aanvaarde vorm en geen woordeboek of leerboeke met 'n konsekwente spelbeeld nie. Die grootste groep dosente, self in Engels geskool, was begryplikerwys geneig om 'n vertaling uit Engels voor die voet te volg. Sommige het gemeen dat 'n ‚internasionale' spelling bestaan en as maatstaf moes dien. In werklikheid is daar nie so iets nie —elke Europese taal verklee tog sy mediese terminologie volgens sy eie taalvorm. Net die internasionaal aanvaarde Latynse benamings in die anatomie, en ten dele die patologie, is werklik internasionaal.[6] Geleidelik ook moes ingesien word dat elke taal oor sy eie volkswoord saam met die verwerkte of aangepaste Latynse of Griekse wortelwoord beskik. Op ieder vakgebied het Afrikaans toe reeds sy beslag begin kry, oral met as gemeenskaplike uitgangspunt die Akademie se spelreëls. Daarom is hierdie spelreëls en die Akademie se woordelyste reeds in 1952 as amptelike beleid en voorbeeld vir die Fakulteit van Geneeskunde in Pretoria aanvaar. Sedertdien het hierdie reëls tot 'n steeds wyer kring uitgebrei en het die Afrikaans-mediese taalgebruik ook sy fondament gevind; hierop word tans gebou om die nodige woordeboek ook die lig te laat sien.

Met so 'n kort bestaan kan dit moeilik verwag word dat op medies-tegniese gebied 'n enigsins omvangryke Afrikaans-mediese literatuur al kon ontstaan. Reeds voor 1944 was daar enkele mediese proefskrifte in Afrikaans en sedertdien het ruim 'n twaalftal keurige geskrifte bygekom. 'n Klein groep mediese boeke in Afrikaans het ook die lig gesien.[7-12] Mediese verslae aan amptelike liggame word reeds as dokumente in Afrikaans opgestel. Waar vroeër deur die jare maar enkele artikels in Afrikaans in die *Suid-Afrikaanse Tydskrif vir Geneeskunde* verskyn het, het die amptelike beleid sedert die afgelope 12 jaar om tweetalige redaksionele artikels te publiseer, as aansporing gedien en het die Afrikaanse bydraes gedurende 1959 sigbaar toegeneem tot ruim 'n twintigtal met 'n hele reeks redaksionele weergawes daarby.

Die behoefte aan die geskrewe woord in Afrikaans was egter nog nie voldoende gedek nie. Die student as belanghebbende het immers die boek- of band-vorm nodig waarin die leesstof gelyktydig en in sy geheel in Afrikaans aangebied word sodat hy met die seggingswyse en die woordbeeld vertroud kan raak. Die hoë produksiekoste, geweeg teenoor die nog klein markgebied, verhoed nog die ontstaan van leerboeke wat, in ieder geval tot by die nuwe uitgawe, met tydskrifwerk aangevul sou moet word. Om in hierdie leemte te help voorsien is besluit om 'n tydskrif uitsluitlik in Afrikaans uit te gee en het *Geneeskunde*[13] in Januarie 1959, die feesjaar van Afrikaans, sy verskyning gemaak. As eerste doelwit is gestel bydraes uit al die vakke in die leerplan om die praktiserende arts met ons kernprobleem, die siek mens, by te staan. Die eerste jaar het bewyse gebring van 'n diepgaande belangstelling en van 'n sluimerende lees- en skryf-lus. Die gebruik deur Afrikaanssprekende medici van hul taal in ons beroepslewe het geleidelik gekom, maar dit brei tans vinnig uit. Die Afrikaanse taalgebruik vind reeds in hoër geestelike inspanning, in die beroep, en in navorsing 'n natuurlike plek langs die taalgebruik van ouer Engelssprekende kollegas wat reeds soveel tot ons geneeskundige welvaart bygedra het.

VERWYSINGS

1. Burrows, E. H. (1958): *A History of Medicine in South Africa.* Kaapstad: A. A. Balkema.
2. Inligting verstrek deur die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad, Februarie 1960.
3. *Gedenkboek oor Geskiedenis van Universiteit van Pretoria,* in druk.
4. Wet op Geneeshere, Tandartse en Aptekers, Nr. 13 van 1928.
5. Minimum Leerplan vir Geneeskunde, Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad, 1959.
6. Kopsch, J. (1957): *Nomina Anatomica.* Stuttgart: Georg Thieme.
7. Mönnig, H. O. (1944): *Parasiete en Parasitiese Siektes van die Mens.* Johannesburg: Voortrekkerpers.
8. Du Toit, F. S. (1944): *Stryd teen Siektes.* Johannesburg: Voortrekkerpers.
9. *Idem* (1945): *Geslagsiektes.* Johannesburg: Voortrekkerpers.
10. Steyn, D. G. (1949): *Vergiftiging van Mens en Dier.* Pretoria: Van Schaik.
11. (*a*) Brink, H. E. (1952): *Menslike Fisiologie,* bd. 1, 2e uitg. Stellenbosch: Universiteits-Uitgewers en Boekhandelaars.
    (*b*) *Idem* (1957): *Ibid.,* bd. 2, 2e uitg. Stellenbosch: Universiteits-Uitgewers en Boekhandelaars.
12. V. Mihalik, P. (1951): *Algemene Weefselleer.* Johannesburg: Daghreek.
13. Redaksioneel (1959): Geneeskunde, 1, 4.

THE MEDICAL ASSOCIATION OF SOUTH AFRICA: ITS ROLE IN THE PAST AND ITS IDEALS FOR THE FUTURE

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Our Association is something which we take very much for granted. It provides us with a weekly *Journal* in which we may publish or read scientific articles, and in which news of the work of the Association is published. All members belong to one or other of the Branches or Divisions which are spread over the country and which make it possible for

members to discuss medicine or merely let off steam to colleagues. Even if we do not participate in the activities of the Association there is a feeling of comfort in knowing that the Association does exist, should need arise.

If we turn to the Articles of Association and consider the function of the Medical Association, we see that its purpose is 'to promote the medical and allied sciences and to maintain the honour and interests of the medical profession'. This means that, apart from being a learned society to assist in the development of our medical and scientific knowledge, the Association accepts the responsibility for its ethical rules. This is probably the most important factor in developing the high standard of integrity which we like to feel is associated with our profession.

Further, in maintaining the interests of the profession, the Association has become the watchdog of both the professional and financial interests of its members. There are probably various views on the question of how successfully the Association has achieved these objects. Whatever these v ews may be, it is true that the Association is recognized as the mouthpiece of the profession and it has been used by the Government and Provincial authorities as the body that represents the medical profession. No rival has developed in this field.

There is a long history behind the ultimate development of the Medical Association of South Africa. During the latter half of the 19th century, medical societies developed independently in various areas in South Africa. Towards the end of this period there were between 700 and 800 doctors in practice and there were 10 medical societies or branches. The purpose of each appeared to be to control ethics and to lay down medical fees. If it is kept in mind that at this time all medical men received their academic training in Europe in many different medical schools—with their differences in standards and background—one would expect a varied and devious approach to medical problems. The amount of unity which has been developed is therefore most commendable. It was only in 1922 that the first 2 medical graduates at the University of Cape Town received their medical degrees.

UNIFYING INFLUENCES

There were two important unifying influences at work during this period:

The one was the holding of South African medical congresses, the first of which was held in Kimberley in 1893. This was the beginning of the development of a national medical organization whose chief purpose was to arrange scientific meetings. From the beginning the decision was to hold Congresses annually in the various centres.

The other unifying influence was the development of the *South African Medical Journal* which arose essentially as the mouthpiece of scientific medical thought. In the early days the development of a journal depended upon the energy and initiative of an individual doctor, and some of the early attempts proved abortive. With the holding of the first South African Medical Congress in 1893 the most important practical outcome was undoubtedly the re-establishment of the *South African Medical Journal*, which was now no longer the financial and editorial responsibility of an individual but became the 'Organ of Congress'.

The list of subscribers to this Journal rose to 270 by 1897, but it remained on a shaky foundation and in 1899 publication was suspended and never revived. Private enterprise provided the *South African Medical Record* in 1903, and the Witwatersrand Branch provided the *Transvaal Medical Journal* in 1906. In 1926 the *South African Medical Record* merged with the *Transvaal Medical Journal* to become the present *South African Medical Journal*. It was, however, many years before unity was achieved by the medical profession with its many societies and branches.

There is no doubt now that the early pioneers of medical organization laid the foundations for medical politics and professional union in South Africa, so that ultimately the Medical Association of South Africa came into being in 1926, uniting the previous societies and branches. The newly-established Medical Association now took over the tradition of holding annual medical congresses and accepted the responsibility for the publication of the *South African Medical Journal*.

It is interesting to note that the first President and Chairman of the Federal Council, appointed in 1926, was General Orenstein, one of the great medical men of South Africa, who is only now contemplating retiring from active medical work.

The basic principles which were incorporated into this new Association were freedom and democracy; freedom because its essence is self-control as opposed to some form of outside direction, and democracy because the people who exercise control are the ordinary members of the profession, duly elected by their colleagues. These principles we have successfully preserved through the years. We still retain our freedom in the practice of medicine and have, to a large extent, remained free of government interference and control.

Specialism has developed apace with the great advances in scientific medicine since the formation of the Medical Association. Groups have been formed in each speciality within the Association. These Groups have become important bodies which further the interests of their members by arranging scientific congresses in each speciality, and by acting as a forum in their particular spheres of medicine.

Private Practice and Medical Insurance

We have always believed that the best medical service for the public can be provided by us through the medium of private practice and the particular kind of doctor-patient relationship associated with it. The cardinal principles involved are, firstly, free choice of doctor by the patient, and free choice of patient by the doctor and, secondly, payment on a 'per service' basis.

In the field of private practice we have done a great deal to encourage and develop medical insurance. In the face of the great scientific and technological advances which have taken place and are continuing with ever-increasing momentum, an ever-widening field of medical service is available to the public—but at continually increasing cost. We have assisted in the development of medical aid societies, and in the past 20 years they have provided medical insurance for many groups of workers in the middle and lower-middle income groups. Our special contribution has been to provide a fixed tariff which is an appreciable reduction on private fees. The profession has further sponsored a Medical Services Plan which is at the moment a pilot scheme in Johannesburg, but is providing comprehensive insurance against sickness.

The field of medical insurance has also been entered by

some of the larger mutual insurance companies, and in this field we are attempting to create relationships which will develop a service good for both the public and the profession.

Medical Education

I think we can say that this is a time of great ferment in medicine. At the First World Conference on Medical Education held in London in 1953 and organized by the World Medical Association, Sir Lionel Whitby concluded his Presidential Address in these words: 'Medicine today demands much from character, intellect and practical ability, and medicine also provides a wide variety of opportunities for all kinds of talent. But talents will be wasted or misused if the structure and context of medical education are faulty and if medical educationists remain complacently satisfied with themselves and their methods'.

Medical education in its widest sense is very much the concern of the Association. We were the sponsoring body which launched the College of Physicians, Surgeons and Gynaecologists of South Africa. The biennial Medical Congresses and the congresses organized by the Groups in their own speciality, are held under the aegis of the Association and are a most important and vital contribution to medical and scientific facilities in South Africa. Furthermore, in the past few years we have been responsible for arranging for leading medical scientists from overseas countries to contribute to our Medical Congresses and also visit our university centres and our main Branches. Concerning this I should like to quote W. M. Arnott, Professor of Medicine at Birmingham, England, who said recently in Chicago: 'The lifelong maintenance of a high standard of informed, critical and conscientious practice depends more than anything else on the avoidance of professional isolation. Where doctors are continuously subject to the kindly mutual criticism and approbation of their peers, it becomes difficult for them to allow their standards to slip and their minds to crystallize'.

International Affiliation

Our Association was one of the founder members of the World Medical Association, which has now been in existence for 14 years, and has 55 medical associations as constituent members. We are also a member of the Commonwealth Medical Conference which has been in existence since 1949.

The Future

So far I have mainly dealt with some of the principles and achievements of the Association. Let me now ask the question: In what direction will the Association proceed in the future?

The Association will have much to do in following the well-worn paths in a sustained attempt to maintain the honour and interests of the medical profession. There are, however, two paths of service which I believe the Association would do well to follow.

First, I consider we should be prepared to give a lead in South Africa in medico-sociological problems of public interest. Such problems include alcoholism, road accidents, mental health, geriatrics, and tuberculosis, to mention just a few. These are problems in which we should be able to give real assistance. The Association should be able to arrange for study groups, who could produce valuable reports in their particular fields.

Secondly, we should be prepared to provide help and to give a lead in Africa. The World Medical Association is divided into regions. Africa is not yet a separate region but is attached to the European region. South Africa is excluded from this arrangement and has dealings with the headquarters of the World Medical Association. There are 15 Branches of the British Medical Association in East, Central and West Africa. Ghana has an independent Medical Association which is in the process of achieving membership of the World Medical Association. Ghana is not as yet producing doctors from its own University. Nigeria, we understand, is likely to set up a separate medical association when it achieves political independence. The first group of medical students will qualify later this year from its own University. The Central African Federation is now in the process of reorganization with a view to bringing its various branches into one Association.

Ghana, with a population of 5½ million, has in the region of 113 doctors. Nigeria, with a population of 36 million has about 1,000 doctors. South Africa, with a population of 14 million, has about 8,000 doctors. These figures make one feel that we should have a very considerable amount to contribute in the medical field in Africa.

It is obvious that there is still much to be done. The individual doctor can make his contribution by, at least, being a member of his professional body—the Association. Its effectiveness must depend upon the support it receives and it exists to help, and to speak for, every member of the profession. Should we not therefore make the Jubilee Year a year of effort to achieve something like one hundred per cent membership?

DOELSTELLINGS VAN DIE FAKULTEIT GENEESKUNDE VAN DIE UNIVERSITEIT VAN STELLENBOSCH

F. D. DU T. VAN ZIJL, CH.M., F.R.C.S.

Professor van Chirurgie en Dekaan van die Fakulteit van Geneeskunde van die Universiteit van Stellenbosch

Die ontstaan van die Geneeskundige Fakulteit van die Universiteit van Stellenbosch, soos dit ook die geval was met die Geneeskundige Fakulteit van die Universiteit van Pretoria, spruit uit die ernstige behoefte om geneeskundige dienste te lewer aan 'n groot gedeelte van ons bevolking in 'n taal, met sy idioom, wat deur hierdie bevolkingsgedeelte verstaan word. Op hierdie wyse voel die siekes tuis onder diegene wat hulle behandel. Deur middel van so 'n geneeskundige fakulteit word daar 'n omgewing geskep waarin nie net die pasiënte nie, maar ook die verpleegsters, die administratiewe personeel en andere, met groter gemak en vrymoedigheid, en dus ook met meer doeltreffendheid, kan beweeg en werk.

Naas die behoefte van die Afrikaanssprekende pasiënt is daar die behoefte van die Afrikaanssprekende student, sowel uit die platteland as uit die stad, om deur die medium van sy eie taal opgelei te word. Met sy eie kennis en agtergrond van

die Afrikaanse leefwyse en denkwyse werk die student dan terselfdertyd mee in die skepping van 'n opleidingsinrigting en 'n opleidingshospitaal wat aan albei doelstellings beantwoord. Noodwendig bring dit ook mee die opleiding van verpleegsters en personeel van die geneeskundige hulpdienste waarsonder die doelstellings nie ten volle bereik kan word nie.

Navorsing

Die hoogste strewe van die inrigting kan egter alleen dan bereik word wanneer die wetenskaplike peil daarin hoog gehou word. Die geneeskundige wetenskap maak snelle vordering. Om in staat te wees om daarmee tred te hou en om daartoe 'n bydrae te kan lewer, moet die allergrootste klem op navorsing gelê word. Sonder navorsing sal die fakulteit nie volwaardig word nie, en sal die opleiding noodwendig daaronder ly.

Saam met navorsing word die opleiding van nagraadse studente beklemtoon. Om te verseker dat die opleiding genoegsaam prakties van aard is, word van die nagraadse student 'n besondere lang tydperk van kliniese assistentskap vereis.

Integrale deel van 'n Universiteit

'n Geneeskundige fakulteit is verder 'n nodige toevoeging tot enige universiteit om aanvullend met die ander natuurwetenskaplike fakulteite te wees. Met hierdie byvoeging is ons oudste Afrikaansmedium universiteit in staat om 'n voller bydrae te maak, en diens te lewer aan 'n vinnig groeiende Suid-Afrikaanse bevolking.

Die jong fakulteit is gesteld op sy identiteit. Hy soek egter nie om sy identiteit in isolasie te behou nie, maar juis om dit in samewerking met ander dergelike inrigtings en susterfakulteite in Suid-Afrika en in die buiteland uit te bou. Daarom soek hy steeds hul vriendskap en samewerking; daarom beywer hy hom ook vir ons gemeenskaplike voordeel, en sal sy strewe steeds wees om niks te doen om die belange van ander te benadeel nie. Waar hy 'n bydrae in belang van die wetenskap en in belang van die geneeskundige opvoeding in Suid-Afrika kan maak, sal dit hom groot vreugde gee om dit in medewerking met suster-fakulteite te doen.

Ten opsigte van die jong aspirant-geneesheer, wie se opleiding aan ons toevertrou word, is ons uitgangspunt dat hy as geneesheer sowel as mens die allerbeste toerusting vir sy taak werd is. Ons verkeer onder die indruk daarvan dat hy in wetenskaplike sin ten volle toegerus moet wees vir die taak wat op hom wag, maar ons besef dat, naas sy taak as geneesheer, hy ook 'n taak as landsburger het. Om hom hiervoor voor te berei, is 'n doelstelling wat ons met woord en voorbeeld nastreef.

Oor twee faktore wat van die grootste belang by die opbou van 'n nuwe fakulteit is, is ons opreg dankbaar. Die eerste is dat ons met 'n span jong, goed-opgeleide, entoesiastiese wetenskaplikes kon begin; manne wat vasbeslote is om 'n sukses van hul taak te maak. Die tweede is dat ons deel vorm van 'n Universiteit waar suiwere wetenskap en harde werk tradisie is, 'n Universiteit wat rigting gee en inspireer.

Ons is bewus van die probleme wat nog opgelos moet word. Gelukkig sien ons hulle nie soseer as probleme nie, maar as 'n uitdaging en 'n geleentheid.

REMINISCENCES OF A GENERAL PRACTITIONER

R. SCHAFFER, M.A., M.D., *Queenstown*

I arrived in Sterkstroom in 1924 with a recently acquired M.B. diploma; unlimited confidence in my ability to deal with all major medical, surgical and obstetric problems; a Dublin-made and equipped midwifery bag and a second-hand Ford bought on credit for £150. This car had no self-starter, no detachable wheels and no lights unless the engine was running. I sat on the car, not in it.

The midwifery bag contained a combined douche-can and sterilizer (Rotunda model), axis-traction forceps, a perforater, an assortment of clamps, needles and catgut, and also a pubiotomy needle with Gigli's saw (I actually used this implement with great success). I also owned a variety of scalpels, a second-hand amputation saw, a chisel and mallet for emergency mastoid surgery and, of course, some anaesthetic masks and a choloroformdrop-bottle. I had also been given a Clover's ether inhaler. In addition I had an assortment of second-hand instruments which had been given to me by various friends—the most useful instruments being a set of dental forceps and a set of metal urethral dilators. I had had considerable practice in using these implements as a hospital resident and this experience proved to be very useful.

My Mobile Dispensary

I bought a set of syringes in a genuine spirit-proof case. The price was reasonable and the quality first class—both quality and price are now only a memory of days long passed. I had an assortment of hypodermic tablets as well as ampoules of camphor in oil with ether, ampoules of pituitrin and ampoules of electrargol—a non-specific cure for all specific infections. There were metal-covered bottles for chloroform, lysol, tincture of iodine, and liquid extract of ergot and also a bottle containing biniodide tablets.

A firm of wholesale chemists had, on credit, supplied me with an assortment of drugs, pills, powders, bottles, bandages, dressings, and splints. I also owned a beautiful wooden box divided into numerous compartments containing bottles of various sizes. This was my mobile dispensary and it fitted into my Ford. The smaller bottles contained standard tinctures, the medium-sized bottles concentrated stock mixtures, and the larger bottles labelled *Aqua Tapi* and *Aqua Tanki* respectively contained the necessary diluent for the contents of the smaller bottles. When visiting a farm, dispensing had to be done in public. The relatives all wanted to see what went into the bottle and the potency of the mixture dispensed was considered directly proportional to the number of preparations used in its make-up. Great care had always to be taken in measuring the exact quantity of *aqua* required. I found, after a time, that a mould would grow in the *aqua* and, to prevent this, I added a small amount of chloroform water. Had I not done this I might perhaps, quite accidentally, have anticipated the discovery of penicillin.

Conditions of Practice

I arranged accommodation at a local hotel at an inclusive charge of £5 per month. I hired rooms for use as a surgery and dispensary for £2 10s. per month and engaged a Native boy for approximately £1 10s. a month. There was no tele-

phone, I required no receptionist and I doubted if I would ever need a bookkeeper. The only telephone in the village was at the local post-office.

My first call was on the well-established local practitioner, who received me in a very friendly manner and offered to give me all assistance possible. He certainly helped me to establish a practice because he persuaded all the poor of the village to send for me, particularly at night. Those farmers who never paid their accounts were also referred to me. He informed me of his usual tariff of fees and I agreed to charge exactly the same. The fees were 7s. 6d. a visit, 5s. a consultation and 3s. 6d per mile each way for travelling. This fee was traditional and based on the average speed of the horse which travelled 6 miles an hour. In this way the doctor earned a fee of 21s. per hour. The charges for medicines ranged from 2s. 6d. to 7s. 6d. a bottle depending not on the contents but on the size of the bottle. The fee for a confinement was £5 5s., which included antenatal care.

The first person who walked into my surgery was a farmer, who was considered a wealthy man, but this was not known to me at the time. He wanted to know if I was the new doctor and if I could pull teeth. When I had satisfied him as to my identity and qualifications he wanted to know 'how much?'. I quoted him the standard fee which was 7s. 6d. with an injection and 5s. without an injection. When he asked what it would cost to pull 2 teeth I quoted 15s. with and 10s. without an injection. After he had convinced me of his poverty he persuaded me to pull 4 teeth for the price of 2 and then called his wife, who had been waiting outside in the family Cape-cart, and asked me to pull 4 of her teeth without an injection.

Having learned to pull the teeth of Dublin Metropolitan policemen, I had no difficulty in extracting 4 of the lady's teeth and, to show my sympathy for suffering humanity I gave her an injection of cocaine even though this had not been included in the contract. The operation was so successfully performed that my reputation as a general practitioner was made

The nearest hospital was at Queenstown—36 miles distant and just over 2 hours by fast car and about the same time by train. I can now travel the distance in 35 minutes, but the train has adhered to the old time-table, with this difference, however, that it is not always as punctual as it used to be. Farm roads were very bad and even main roads were impassable in rainy weather, and many visits to farms had to be completed on horseback. When my services were required on a farm, a messenger was usually sent for me.

Farm visits were the major source of income and as there was no telephone there could, fortunately, be no telephone consultations. Surgical cases were taken to Queenstown where they were very skilfully operated on by my friend, the late Dr. Harry Lewis. Occasionally, patients were too ill or too obstinate to be moved. Sometimes weather conditions and road conditions made it quite impossible to move a seriously ill patient, and during the next 2 years I performed several appendicectomies and one mastoid operation on a kitchen table without a nurse, without an assistant and without an anaesthetist. I used spinal anaesthesia for the appendicectomies, and a child with a very acute mastoid was put to sleep with chloroform and the mastoid was then opened before the child woke up. The child fortunately recovered from both the anaesthetic and operation.

The only patients who paid cash were the few Native patients I saw. The fee was 2s. 6d. for a child including medicine and 5s. for an adult. The inhabitants of the village paid their accounts occasionally, perhaps, and it was customary that farmers only received their account once a year during the shearing season. If the wool cheque was sufficient the doctor also received a small share.

It did not take me very long to establish a very extensive practice and to build up a very substantial overdraft. I was frequently called to see patients in the surrounding districts and was often asked to see patients at the request of other doctors. After I had been in Sterkstroom for about a year I was persuaded to open a nursing home. The Church promised to assist, the farmers offered their support, and a very attractive young nurse agreed to work for me. The venture was not very profitable but provided me with ample experience, particularly in economics. I was also appointed railway medical officer at a salary of £108 per year.

Sterkstroom is a railway junction and, as such, it was necessary for an engine to be permanently stationed there. As the engine required a driver, the driver and his family had to live at Sterkstroom. The driver has long since died but the engine is, I believe, still in use. Three times a week this particular driver went on duty at 2 o'clock in the morning and at least twice a week used to wake me on his way to the station because he had a headache. At first he was treated with sympathy and given the necessary pills, but after numerous nocturnal disturbances I was no longer the sympathetic railway doctor. Instead of an aspirin or similar tablet I gave him a 5-grain calomel tablet and assured him that the cure would now be permanent. It was!

One Saturday afternoon while I was playing tennis, I was urgently sent for by the youngest daughter of a railway employee with the urgent request that her mother required raw linseed oil and Condy's crystals (potassium permanganate). I suggested that this prescription could wait until the Monday and I continued with my game. A little later another child of the same family arrived and repeated the request for Condy's crystals and linseed oil. This request was also refused. A little later the eldest child of this family came along and asked me please to let her mother have the linseed oil and the crystals because they were required urgently. When I refused to agree to this request the child burst into tears and informed me that the visitors would be gone by Monday and they had to get the floors polished before they arrived the next day.

A young fireman, who possessed a second-hand motor cycle, developed an enormous appetite for castor oil—almost every day he sent for castor oil until I discovered that he thought Castrol and castor oil were the same and that both could therefore be used for motor cycles.

In 1926 I was able to persuade a colleague to take over my practice with all its responsibilities and I joined Dr. Lewis, of Queenstown, as an assistant.

Queenstown

In 1926 Queenstown was already a progressive town and the educational and inland commercial centre of the Border and Eastern Cape. There was a good hospital and also a well-run private nursing home. The part-time medical superintendent of the hospital, Dr. W. Paisley, had practised in Queenstown since the Boer War and his many friends are very pleased that he is still actively interested in the medical

profession and the Medical Association. He was a model superintendent who never interfered with the smooth running of the institution under his control.

The district surgeon was Dr. Cranke, a wise old general practitioner of the old school who taught me a great deal about the diagnosis of infectious diseases. He was expert in the diagnosis of typhus, typhoid and smallpox.

I learned a great deal in these early days, not only from my chief, Harry Lewis, and from other practitioners, but also from some of the wise old nursing sisters who knew more about treatment than had ever been taught in medical schools.

The hospital possessed a very elaborate X-ray unit with rotating rectifier and gas tubes. The controls had been manipulated by so many inexpert hands that the machine no longer worked, and it was replaced by a low-powered semi-portable unit which could show 'bone outline' and occasionally demonstrate a fracture. There was no pathological laboratory and specimens were sent to the South African Institute for Medical Research. The service given was very satisfactory and reports were received more quickly in 1926 than in 1960. There was no doubt less work both for the pathologists and the postal officials.

The operating theatre was small and extremely hot in summer. The table was old-fashioned even in 1926 and the theatre light was designed by Harry Lewis and had been manufactured by the local plumber, but it was very much better than some more expensive lights. The standard of work was better than it was in most centres, and some of the medical practitioners, particularly Harry Lewis and Jimmy Ritchie, were extremely competent operators. My first appearance in the operating theatre was in the role of anaesthetist and I arrived with a bottle of anaesthetic ether even though I was told that ether could not be used at a high altitude and in a hot climate and that, in any case, chloroform was a safer and better anaesthetic agent. I introduced this dangerous substance most successfully and, before long, it was used by most practitioners.

Fees in Queenstown were very much the same as they had been in Sterkstroom, but the greater part of our income was derived from surgical practice. The fee for an appendicectomy was 25 guineas and for a cholecystectomy or hysterectomy 30 - 45 guineas. There were, of course, no medical aid societies and surgical fees were usually arranged with the patient according to his ability to pay. Patients were treated as free patients whenever this was considered necessary, and we all did free work at the hospital in our capacity as honorary medical officers. The Medical Committee, of which we were all members, had a great deal to say in the administration of the hospital and our recommendations were almost invariably accepted.

Methods of Treatment

In 1929 I went overseas for purposes of postgraduate study and on my return Dr. Lewis left Queenstown. In Queenstown at that time all practices were dispensing practices. Doctors did not require receptionists and patients were not required to make appointments. Consulting hours were between 11 and 12 midday and 2 and 4 p.m., and patients waited until they were attended to. Many of the farmers had telephones, but roads were bad and country trips were still a major source of income. I engaged a receptionist towards the end of 1930 at a salary, considered excellent at that time, of £5 per month. The price of my expensive car was about £400 and a more useful car, such as a Ford or Chev. could have been bought for under £300. There were no expensive drugs and stock mixtures were adequate for most conditions. There were always cases of pneumonia and enteric fever in hospital and if they survived it was due to the expert nursing and not to the drugs used. Camphor-in-oil with ether was the most commonly used injection and had the great advantage of never doing harm. About this time two quinine preparations were introduced for the treatment of the pneumonias. These were solvochin and transpulmin and both remained in popular use until 1946.

There were many cases of syphilis, and neosalvarsan, mercury, and intramuscular bismuth were used extensively. I saw 2 fatal cases of exfoliative dermatitis following treatment with neosalvarsan. Two of my patients died of agranulocytosis, caused by arsenic in one and by veramon—a popular amidopyrine-containing analgesic tablet—in the other.

Gonorrhoea was treated according to the methods used during World War I—and not cured. The first real advance in the treatment of this prevalent condition was the introduction of short-wave diathermy.

I well remember my introduction to the first of the sulpha drugs. I had a case of severe puerperal septicaemia and a trade representative gave me samples of red prontosil for intravenous use. The result was dramatic. Streptococci, gonococci and meningococci had great respect for prontosil Other sulphonamides such as sulphanilamide and soluseptasine soon displaced prontosil but were not superior. It was only in 1939 when sulphapyridine (M & B 693) was introduced that effective chemotherapy against the pneumococcus became possible. Therapeutic failure of sulphapyridine was usually due to insufficient dosage, because of fear of crystalluria. This could be prevented by the use of alkalis and by adequate fluid intake, given intravenously if necessary.

In 1924 I did not diagnose coronary occlusion, but patients nevertheless died of the disease. I am satisfied that the incidence of ischaemic heart disease has more than doubled in the past three decades. Carcinoma of the lung was also not diagnosed and many a family history of tuberculosis was, in fact, a history of carcinoma.

In 1930 amoebiasis was not very prevalent in the Eastern Cape. The disease was usually contracted in Natal and the Eastern Transvaal. In 1931 Dr. Ramsay, of Molteno, described cases of hepatomegaly successfully treated with emetine (report to meeting of Queenstown Division, M.A.S.A.). I had seen some of these cases and proved them to be amoebiasis. The patients had never been outside the Molteno and Dordrecht districts. I have since seen many cases of amoebiasis contracted in this area.

My colleagues were more interested in surgical conditions than in medical problems. The most important advance in surgery was the introduction of the modern treatment for paralytic ileus. It took many years to persuade doctors and ward sisters not to irritate the post-operative bowel with purgatives and enemata. It also took many year to persuade colleagues and nurses not to use 'donkeys' (bolsters) and to recognize the importance of the prevention of deep-vein thrombosis.

The War Years

When war was declared I volunteered for service and in May 1940 was at the Zonderwater training camp. When my assistant also joined the army the practice had to be closed for the duration of the war.

Work in military hospitals provided useful experience as well as excellent teaching from some very eminent senior colleagues. It also confirmed that no individual doctor can give adequate service without the cooperation of colleagues trained and experienced in different fields, and that highly specialized knowledge was most useful when based on wide practical experience.

It is impossible to give up a practice without very considerable loss, and war is never entirely pleasant, but the friendships made and the comradeship enjoyed amply compensated for the sacrifices made. While I was on military service the South African Medical and Dental Council saw fit to place me on the register of specialist physicians, but on demobilization I voluntarily reverted to the status of a general practitioner.

My practice was soon re-established and after a year a colleague, who had worked with me in military hospitals joined me as assistant and later became a partner. Soon another assistant joined the firm which has grown over the years, so that now we are 5. Each is a general practitioner able to do all routine general practice work, but each has his special interests and has had special training in his particular field. Group practice is, in my opinion, the ideal practice for the smaller hospital town. It is pleasant for the doctor and also for the patient.

Changing Patterns of Living

The past 20 years have been years of industrial revolution and it was inevitable that there should have been a shift of population from the platteland to the town and from the village to the city. There has also been a change in the pattern of living. The good road and the closed car make it possible to move a patient to the nearest hospital. It is safer to move the patient 100 miles to a well-equipped and well-staffed hospital than to leave him in a village nursing home where equipment and staff cannot be adequate. Should hospitalization not be necessary it is usually possible to take the patient to the nearest doctor. It is cheaper than asking the doctor to visit the farm. A telephone call to the doctor may also make a visit unnecessary.

Babies are no longer born on the farms and it is cheaper and better for the patients to go to the nearest town where there is a well-equipped maternity home or hospital. It was inevitable, therefore, that the doctor should leave the village and migrate to the big city.

One village which supported 4 doctors in 1924 now has 2. Villages which had 1 doctor only, now have none. The doctor in the town no longer dispenses medicines, but the country doctor is compelled by circumstance to dispense. He not only dispenses stock mixtures but also supplies his patients with expensive antibiotics and corticosteroids. He is not always paid for the drugs he dispenses. His car, which used to cost £300, now costs £1,200. He needs more equipment than was necessary in 1924 and he also requires a receptionist.

The increase in medical fees has been very moderate when compared to the increased cost of providing the service. When the country doctor needs a holiday he also needs a *locum tenens*. The 1926 *locum tenens* was pleased to receive £1 11s. 6d. a day all found. In 1960 'locums' are almost unobtainable and the fee is from £5 5s. to £7 7s. a day all found.

The general practitioner in the large city may see more patients than his country colleague, but his income is derived almost entirely from domiciliary visits and consultations. In addition he has the expensive privilege of driving many miles through dense traffic.

The post-war years have been most interesting. Society, both White and non-White, has largely become an urbanized, industrial society and contract practice has, in many cases, replaced traditional private practice.

Rapid progress in medical science has increased the citizen's expectation of life, and has also increased the need for and the cost of investigations and treatment. The high cost of modern drugs, essential in many cases, has made the drug bill a greater burden than the doctor's fee.

While the general practitioner is gradually adapting himself to the changing world, micro-organisms are rapidly adapting themselves to an antibiotic-saturated environment. While drug manufacturers are producing antibiotics of ever increasing variety and price, their indiscriminate use is generating numerous strains of antibiotic-fast organisms.

When I was a young man I did not intend to become a general practitioner, but economic circumstances forced me to become one. There were no well-paid hospital posts in 1924 and a junior medical officer in a teaching hospital was fortunate to earn £10 a month. The young doctor who had to earn a living had to become a general practitioner.

I had many regrets in 1924, but have had no regrets since. There has never been a more interesting era in recorded medical history. General practice has always been a rewarding experience. I have certainly enjoyed my first 36 years.

DIE GESINSDOKTER IN SUID-AFRIKA

J. VAN SCHALKWIJK, M.A., B.CHIR., M.D., *Graaff-Reinet*

Tempora mutantur et nos mutamur in illis. Dit is nader aan die waarheid om te beweer dat die mens self tye en omstandighede verander en dan sukkel om hom daarby aan te pas.

Dit is 'n feit dat geweldige veranderinge in die verhouding van dokter tot pasiënt en die gesin, en andersom, plaasgevind het. Om die oorsake hiervan te betrag is interessant. Omdat die meeste hedendaagse praktisyns grootliks onbekend is met die vroeëre toestande, veral op die platteland, wat dié verhoudinge bepaal, bewerkstellig en bestendig het, en derhalwe slegs 'n vae begrip hiervan kan hê, wil ek kortliks die een en ander boekstaaf. Ek wil net put uit persoonlike ondervinding en kennis opgedoen gedurende die tydperk van my praktyk, wat ek as jong dokter uit Engeland 48 jaar gelede begin het.

Die verhouding tussen Dokter en Pasiënt

Wat was die verhouding van dokter teenoor pasiënt en gesin? Reeds vroeg in sy lewe het die dokter ondervind dat

siektes so dikwels nie die verloop volg en die verskynsels vertoon soos sy leerboeke hom vertel het nie. Die diagnose bly duister, en die toegewyde dokter verduur slapelose nagte waar hy, as nuweling op die dorp, net een ding voor oë het—die genesing van die sieke. Ook dink hy nooit aan sy eie gerief nie. Mooi weer, kwaai weerlig rondom hom op die wye vlaktes van die Transvaalse hoëveld, koue nagte met die temperatuur vyftien grade onder vriespunt, reën en modder en gesukkel met die Fordjie, — hy is altyd gereed om uit te ry na die plaas toe. Hy bekommer hom nie dat hy sy lewe in gevaar stel met ernstige aansteeklike siektes soos bv. die dodelike griep van 1918 nie. Hy dink aan geen vergoeding nie; dit is vir hom om die ewe of die mense ryk of arm is. Hy het net alleen met die pasiënt en sy belange te doen.

Sy posisie in die afgeleë dorpe was gewis uiters moeilik. Hy kon hom tot niemand wend om hulp en advies nie. En welke middele het hy destyds tot sy beskikking gehad in vergelyking met dié van vandag? Hy moes alleen en onder die mees primitiewe omstandighede bevallings met kraniotomie, ribreseksie vir empieem, beklemde breuk-operasie, en trageotomie op 'n bed by die lig van 'n klein lampie doen. Voorwaar, hy het geleer en tot volwassing gekom in 'n harde en moeilike skool. Vandag se praktisyns ondervind hierdie moeilikhede nooit nie.

Die boere het geen motors of telefone gehad nie. Gevolglik moes hulle met perde dorp toe ry om die dokter te kom roep, of advies en medisyne te kry. Byna elke dag moes hy die distrik in, dikwels met die stampende kapkar van die boer in pikdonker nagte, en soms te perd deur riviere. In daardie dae was *tyd* lank. By die plaas moes hy eet en drink, gesels en soms ook ongerieflik slaap. Daar was nie boere-dorpshuise, hospitale, verpleeginrigtings, los opgeleide verpleegsters, of klinieke nie. Derhalwe is die pasiënt selde dorp toe vervoer, en die dokter was verplig om weer en weer na die sieke te ry. Die naaste hospitaal was 100 myl ver, en net bereikbaar per trein eenkeer per dag, en daar was ook die enigste spesialiste—'n karige dosyn of so. Alle behandeling het dus in die huise van die siekes plaasgevind, waar die pasiënt onafgebroke onder die sorg van die dokter was.

Daar was maar min dokters, en die keuse dus beperk. Daarom kon die mense nie so rondspring van dokter na dokter soos vandag nie, en het hulle meesal by een dokter gebly. Die dokter het dus die kans gekry om iedere familie intiem te leer ken, asook hulle huislike en maatskaplike aangeleenthede en moeilikhede. In die geval van elke pasiënt het hy ook die familie se mediese geskiedenis geken, dikwels van die pasiënt se geboorte af tot hy self weer kinders gekry het. Vir een of twee geslagte was hy die huisdokter. Die so gewenste en belangrike kontinuiteit was daar. Hy het geleer om die mense lief te kry en te waardeer; hulle was sy vriende, en hy was bereid om hulle altyd onder alle omstandighede te help. Hulle geluk, verdriet en vreugde was ook syne; en menigmaal het die trane in sy oë gekom waar hy by die sterfbed, of daarna by die wenende familie en die graf gewees het.

Die Verhouding tussen die Dokter en die Gesin

En nou die verhouding van die gesin en pasiënt teenoor die dokter. Hy was die vertroude geneesheer—die geliefde medisynmeester soos die Apostel Lukas hom noem—op wie dag en nag gereken kon word. Naasaan die Almagtige het hy oor lewe en dood beskik. Hy was die raadgewer, slim geleerd; die vertrooster by siektes en die dood. Na hom is opgesien soos dit die geval was met die predikant. Hy moes alles weet van sy vak en ander sake. Eenkeer moes ek die testament van 'n man na aan sy einde verander waarin hy sy ongewenste skoonseun onterf het. Die dokter moes lyke uitlê en pasgebore babas bad en aantrek. Hy was so te sê 'n lid van die familie. Voorwaar was hy 'n gesinsdokter in die volle betekenis van die woord.

Onkunde

Ek noem nog een faktor wat m.i. die toestande bestendig het. Die onkunde, selfs van geleerde mense van die tyd (en tot 'n mate vandag nog) oor die oorsaak, aard en behandeling van siektes en hulle voorkoming was skokkend. Dit het my dan ook beweeg om in 1918 'n alombekende boek *Raad in Tyd van Siekte* te skrywe en te laat versprei. Die gevolge van die onkunde, soos oral in die wêreld van die ontstaan van die mens af, was bygelowigheid en 'n ingewortelde, kinderlike geloof in boererate en in die rate van Tant Sannie en Tant Bettie. Ook was daar 'n sterk geloof in die vroedvroue (Blank en nie-Blank)—die *Sairey Gamps* van dié dae—en veral in die huismiddels. Laasgenoemde was gewoonlik in 'n groen trommeltjie en het so 'n dosyn een-ons flessies met Hollandse medisyne bevat, soos Versterkdruppels, Witdulsies, Rooilaventel.

Daar is altyd eiegeregtige, domastrante mense. Al gee die dokter medisyne word die ou boererate tussenin gebruik, en die advies van die wyse ou Tannies gevolg, soos bokmis en asyn vir masels, hondebloed en die draai van warm, pas afgeslagte skaap- of bokvelle om die bors van die pasiënt, vir die so gevreesde 'inflemasie' van die longe. As die man dan gesond word, kry Tant Bettie die pluimpie, en as hy doodgaan word die dokter geblameer. Een komiese geval moet ek verhaal: 'n Eenvoudige man met 'n swaksinnige epileptiese vrou vertel my dat hy sy vrou sekere pille ingegee het, en dat sy nou beter was. Die pille het hy van klam brood, gemeng met die wit toppe van droë hoendermis, gemaak. So ewe naïef voeg hy by: Maar, dokter, sy het nie hiervan geweet nie. *Sancta simplisitas!*

Soos die Voortrekkers en die pioniers verplig was om selfstandige mense te word—vandaar die uitdrukking dat die boer altyd 'n plan kan maak—so moes die verafgeleë mense ook maar 'selfstandig' optree by die behandeling van siektes. Dié kenmerk was diep ingewortel, moeilik uit te werp, en het behoudend voortgelewe. Selfs in hierdie verligte eeu word nog daagliks middeleeuse medisyne gebruik, dokter of geen dokter nie.

Die Verandering

Wat was nou die oorsake van die radikale verandering? Meer dokters het hulle op die dorpe gevestig, en die rondspringery van dokter na dokter het toegeneem. Dit het byna 'n uitsondering geword dat dieselfde dokter 'n familie jare aaneen behandel. Ek bespreek die redes hiervoor nie. Ook het daar 'n gedurige verskuiwing van dokters plaasgevind: die een aanvaar 'n betrekking; die ander wil sy finansiële posisie verbeter en verhuis na 'n groter plek, en sommer baie gaan spesialiseer. Spesialiste het soos paddastoele opgespring, sodat daar in sekere stede vandag meer spesialiste as algemene praktisyns is. Die mense het tot 'n groot mate spesialisbewus geword. In plaas van dat hulle besef dat 'n spesialis net meer van sekere spesiale, uitsonderlike gevalle as die gewone dokter weet, stap die pasiënt voor die deur van sy dokter verby en gaan die slim spesialis raadpleeg wanneer hy 'n gewone verkoue of seerkeel het—siektes waarvan die

ervare dokter baie meer weet en gesien het. 'n Groot neiging het ook ontstaan om aptekers oor siektes te raadpleeg en medisyne van hulle te kry, omdat dit goedkoper is as om nog die dokter ook te betaal. Baie geadverteerde middels in koerante en tydskrifte, wat hemelhoog geprys word vir byna alle siektes, word gedurig gekoop. Tereg het iemand gesê dat drukkersink die lewensbloed van die kwaksalwer is. Aspirien en sulfapreparate is gewilde middels, wat in baie huise aangetref word. Slegs as die siekte erger word, word die dokter ingeroep.

Die telefoon en motor, waarmee elke dorps- en plaasgesin nou voorsien is, het 'n geweldige verandering in die praktyk van die dokter teweeggebring en dit het sy inkomste ook aansienlik laat krimp. 'n Noodwendige gevolg hiervan was dat die dokter sy gelde baie hoog opgeskuiwe het, waaronder veral die minder bevoorregte mense moet ly. Nou word die pasiënt ook sommer maklik per motor dorp toe gebring, en as die siekte ernstig is, word hy in die boer se dorpshuis, in die hospitaal, of in die verpleeginrigting behandel. Verder het die behandeling oor die telefoon verbasende afmetings aangeneem, sodat die dokter soms nooit eers die pasiënt sien nie. Verpleegsters en verpleeginrigtinge van allerlei aard is volop en pasiënte—veral met bevallings—skakel die dokter uit en word elders behandel. Dikwels word die pasiënt tot hospitale toegelaat waar die huisdokter geen seggenskap het nie, of hy gaan na 'n regeringskliniek waar hy deur wildvreemde geneeshere behandel word—persone wat dikwels geen belang in die familie stel nie, en waar die pasiënt net as 'n 'geval' beskou word. Dit geld ook dikwels vir die spesialis. En as die dokter nog plaas toe ry is alles haastig, want die tyd het deesdae baie kort geword. 'n Ondersoek, 'n inspuiting, medisyne, instruksies—en die dokter jaag terug dorp toe.

Ek wil nog 'n faktor noem, en dit is 'n ongewenste faktor. Daar is beslis 'n hedendaagse neiging—die redes is nie hier ter sake nie—om die edele mediese professie te kommersialiseer. Die dokter wil gou ryk word om te gaan boer of om te gaan spesialiseer.

SLOT

Al die bogemelde faktore het daartoe bygedra om die ou intieme bande tussen die dokter en die pasiënt met sy familie te laat slyt of heeltemal te laat breek. Die algemene praktisyn word stadigaan uitgeskakel deur die spesialis, aptekers, hospitale, regeringsklinieke, verpleegsters en verpleeginrigtinge. Die gesinsdokter van vroeër is of word iets van die verlede, soos die ossewa en die ou kapkar. Die einde van 'n baie ou tradisie het aangebreek. Dat dit 'n tragedie vir die samelewing en 'n ongewenste toestand van sake is, betwyfel ek nie. *Sic transit gloria medicus familiae!*

MINUTES OF MEETING OF FEDERAL COUNCIL HELD IN PRETORIA ON 3, 4 AND 5 MARCH 1960

Following are the Minutes of a Meeting of the Federal Council of the Medical Association of South Africa, held in the Municipal Recreation Club, Riviera, Pretoria, on 3, 4 and 5 March 1960:

Present:

Ex Officio: Dr. P. F. H. Wagner (President of the Association), Dr. A. W. S. Sichel (Immediate Past Chairman), Mr. J. D. Joubert (Honorary Treasurer).

Border Branch: Drs. L. L. Alexander, R. Schaffer, H. M. Segall.

Cape Midlands Branch: Drs. A. P. Albert, L. E. Lane, M.A. Robertson.

Cape Western Branch: Dr. J. C. Coetzee, Mr. J. A. Currie, Drs. M. Helman, A. Landau, Mr. T. B. McMurray, Mr. J. A. S. Marr, Drs. P. F. Oates, A. G. Paterson, F. W. F. Purcell, J. H. L. Shapiro, L. Slabbert, A. A. Zabow.

Eastern Transvaal Branch: Dr. W. M. Bezuidenhout, Mr. D. E. Mackenzie, Dr. E. W. Turton.

Griqualand West Branch: Mr. N. Kretzmar.

Natal Coastal Branch: Drs. A. Broomberg, S. Disler, H. Grant-Whyte, N. A. Rossiter, Mr. A. G. Sweetapple, Dr. A. B. Taylor.

Natal Inland Branch: Mr. B. A. Armitage, Dr. T. H. Whitsitt.

Northern Transvaal Branch: Drs. J. H. Casewell, C. M. Grundlingh, W. H. Lawrance, J. H. Struthers, W. Waks.

O.F.S. and Basutoland Branch: Drs. J. de Beer, F. Hagen, R. Theron, G. F. C. Troskie.

O.F.S. Goldfields Branch: Dr. F. N. Gillwald.

Southern Transvaal Branch: Drs. C. Adler, A. L. Agranat, Mr. W. Girdwood, Drs. J. Gluckman, Seymour Heymann, Mr. C. T. Moller, Drs. H. Penn, T. Radloff, Lewis S. Robertson, T. Schneider, M. Shapiro, S. Spiro.

South-West Africa Branch: Dr. W. H. G. Kuschke.

Transkei Branch: Dr. E. R. Louw.

Vaal River Branch: Dr. W. Chapman.

In Attendance: Drs. A. H. Tonkin (Secretary), L. M. Marchand (Associate Secretary), P. D. Combrink (Assistant Secretary, Transvaal).

Observer: Dr. A. P. Blignault (Editor).

THURSDAY 3 MARCH

The Chairman of Council, Dr. J. H. Struthers, declared the Meeting to be duly constituted at 9.30 a.m. He welcomed members to the Meeting.

1. *Notice Convening the Meeting*, published in the *Journal* of 30 January 1960, was taken as read.

2. *Proxies and Apologies:* The Secretary announced Proxies as follows: Dr. W. M. Bezuidenhout to act for Dr. M. Segal; Dr. J. de Beer to act for Dr. D. Serfontein; Dr. H. M. Segall to act for Dr. J. K. McCabe; Dr. J. Gluckman to act for Mr. J. Wolfowitz.

An apology for absence from Dr. L. R. L. Solomon was noted.

3. *Introduction of New Members:* The Chairman asked that senior members of Branches introduce new members of Council.

Dr. Schaffer introduced Dr. H. M. Segall; Dr. Troskie introduced Dr. F. N. Gillwald; Dr. Turton introduced Dr. W. M. Bezuidenhout.

4. *O.F.S. Goldfields Branch*: The Chairman referred to the Inaugural Meeting of the O.F.S. Goldfields Branch which had been held 3 weeks previously, and stated that the President of the Association, the Assistant Secretary (Transvaal) and he had attended. He welcomed Dr. Gillwald as the new Federal Councillor representing the Branch. Acclamation.

5. *Welcome to President of the South African Medical and Dental Council:* The Chairman extended a welcome to Prof. S. F. Oosthuizen, President of the South African Medical and Dental Council, who was present as an observer, and referred to the excellent relationship which existed between the Association and the Medical Council. He conveyed to Federal Council Professor Oosthuizen's good wishes for a happy and satisfactory Meeting. Acclamation.

6. *Simon van der Stel Foundation*: The Chairman stated that during the previous week he had been approached by the Director of the Simon van der Stel Foundation which was an organization comparable to the National Trust in the United Kingdom. He explained that it was a voluntary organization whose aims were to try to preserve architecture, monuments and land in special areas for the benefit of posterity, and that the Foundation hoped that individual doctors would be prepared to become Foundation Members by paying a subscription of 10 guineas.

Council *Resolved* that the aims and objects of the Foundation be brought to the notice of members of the profession through the columns of the *Journal*.

7. *Entertainment:* The Chairman referred to arrangements for the Federal Council Dinner to be held that evening, and stated further that he had been asked to convey to Council an invitation

from the President of the Northern Transvaal Branch and Mrs. Swanepoel to attend a Cocktail Party at their home on the following evening. *Noted.*

8. *Death of the Association's Patron:* The Chairman reminded members that the late Dr. E. G. Jansen, Governor-General of the Union, had been the Patron of the Association. He had attended the State funeral as the representative of the Association and had addressed a letter of sympathy to Mrs. Jansen. The reply to this letter was read and *Noted.*

9. *Minutes* of Meeting held in East London on 24, 25 and 26 September 1959, were presented. It was proposed by Mr. Armitage, seconded by Dr. Lewis S. Robertson and *Resolved* that the Minutes be confirmed and signed.

10. *Decision Regarding Night Sittings:* The Chairman referred to a notice of motion suggesting that any decision regarding night sittings be made at the commencement of the Meeting. He pointed out that in view of the Dinner arranged for the first evening a night sitting would not be possible, although it was likely that one would be held on the following evening. *Noted.*

MATTERS ARISING OUT OF THE MINUTES

11. *Assistants for Part-time Specialists to Benefit Societies:* Members were referred to Minute 12 of the previous Meeting, and it was reported that the Cape Western Branch had sought the opinion of the Executive Committee of the South African Medical and Dental Council in regard to this matter. The opinion expressed seemed to be contrary to that contained in the resolution of Federal Council.

It was further reported that the Executive Committee had agreed to recommend to Federal Council 'That as this matter is to be discussed by the South African Medical and Dental Council at its forthcoming meeting, no action be taken by Federal Council at this stage'.

In the course of the discussion which followed, it was proposed by Dr. M. Shapiro, seconded by Mr. McMurray, that the correspondence in respect of assistants for part-time specialists to benefit societies be published in the *Journal.* After debate, this amendment was put to the vote and was *Lost.*

The recommendation of the Executive Committee was then put to the vote and was *Carried* by 34 votes to 19. Dr. M. Shapiro requested that the names of the members voting for and against the motion be recorded. They were as follows:

For the motion: Drs. Agranat, Armitage, Alexander, Bezuidenhout, Casewell, Chapman, Currie, de Beer, Gillwald, Grundlingh, Hagen, Joubert, Kretzmar, Kuschke, Lawrance, Louw, Mackenzie, Penn, Purcell, Radloff, L. S. Robertson, Rossiter, Schaffer, Sichel, Spiro, Struthers, Sweetapple, Taylor, Theron, Troskie, Turton, Wagner, Waks, Whitsitt.

Against the motion: Drs. Adler, Albert, Broomberg, Coetzee, Disler, Gluckman, Helman, Landau, Lane, Marr, McMurray, Moller, Oates, Patterson, M. A. Robertson, J. H. L. Shapiro, M. Shapiro, Slabbert, Zabow.

Notice of motion for debate at the next Meeting of Council was given over the names of Dr. M. Shapiro and Mr. T. B. McMurray: 'That the resolution under Item 12 of the Minutes of the Meeting of Council held in September 1959, be rescinded'.

12. *Negotiations with Mines Benefit Society:* Dr. Penn, as President of the Southern Transvaal Branch, reported that a joint meeting would take place on 9 March between the various Branches concerned and the Mines Benefit Society. The question of temporary or permanent appointments would be discussed at that meeting. *Noted.*

13. *Congress Surpluses—Visiting Lecturers' Fund:* It was reported that at the last Meeting of Council it had been decided to establish a Visiting Lecturers' Fund, but that no authority had been received to transfer from a suspense account the amount of the surplus from the Durban (1957) Congress to this Fund. The amount of this surplus was £480 7s. 6d. The Executive Committee had agreed to recommend to Council that this amount be transferred to the Visiting Lecturers' Fund. Council *Resolved* accordingly.

It was reported further that the deficit of approximately £700 on the East London (1959) Congress had been discussed by the Executive Committee and that as this deficit had arisen mainly through the costs incurred in connection with visiting lecturers the Executive Committee had agreed to recommend to Council that the amount of £480 7s. 6d. be transferred from the Visiting Lecturers' Fund to the Border Branch to offset the deficit which had been incurred. Council *Resolved* accordingly.

14. *Method of Award of Medals:* The Secretary reported that the Executive Committee had considered this matter, particularly in relation to the Bronze Medal, and had agreed to recommend to Council that a new rule be added to the Rules Governing the Award of the Association's Bronze Medal, to read: 'Notwithstanding the foregoing rules, it shall be competent for the Federal Council to consider the award of the Association's Bronze Medal for meritorious service to a member of the Association on the nomination of such person by 3 members of Council who shall forward the nomination with a suitable citation, in writing, to the Secretary of the Council 5 weeks before the Meeting of Council at which it is to be considered'.

After a brief explanatory statement by the Chairman, the matter was put to the vote. Council *Resolved* accordingly.

15. *Expulsion from Meetings:* It was reported that notice of motion had been given at the last Meeting of Council over the names of Dr. M. Shapiro and Mr. Moller: 'That the resolution under Item 120 of the Minutes of the Council Meeting of April 1959 be rescinded'.

The mover pointed out that the situation envisaged in the resolution was amply covered by Standing Order 44.

After considerable debate, the motion to rescind was put to the vote and was *Carried* by 41 votes to 3.

Arising out of this matter, it was proposed by Dr. Sichel, seconded by Dr. L. S. Robertson and *Resolved Nem. Con.* 'That the question of the wording of Standing Order 44, dealing with expulsion from Meetings, be referred to the Executive Committee for consideration, report and recommendation'.

16. *Public Relations:* It was reported that a notice of motion over the names of Dr. Lewis S. Robertson and Dr. Purcell had been given at the last Meeting, reading: 'That consideration be given to ways and means by which the Medical Association of South Africa should take an active role in providing information to the public on matters pertaining to health and medical practice in South Africa'.

After short discussion it was agreed that no vote be taken but that the matter be *Noted.*

17. *Resolutions Committee:* It was reported that at the last Meeting of Council notice of motion had been given over the names of Dr. Lewis S. Robertson and Dr. Purcell: 'That soon after the commencement of each Meeting of Federal Council an *ad hoc* sub-committee with power to coopt be appointed, which may be charged to draft resolutions on any matters or items for consideration at a later stage of the Meeting'.

In speaking to this motion, Dr. Robertson stated that he wished to introduce an amendment by the insertion of the words 'under consideration by the Meeting' after the word 'items'. It was *Agreed* that this amendment be accepted; but when the motion as amended was put to the vote after short debate, it was *Lost.*

18. *Report of Committee on Medical Insurance:* The Report was presented by Dr. Lawrance who moved the 2 recommendations of the Committee as follows:

1. That the Medical Association of South Africa recognize insurance organizations which provide prepaid medical care; such recognition to mean that the Association will be prepared to cooperate with these organizations in order to enable them to provide an adequate service to the public.

2. That the cooperation referred to above include the granting of the privilege of a preferential tariff to those groups of members within the insurance schemes who can comply with the income qualifications laid down for approved medical aid societies, on the understanding, however, that the insurance organizations concerned will, in their turn, undertake to pay the accounts of doctors direct and in full.

Dr. Lawrance stated that the Committee had given much time and thought to the matter and wished to assist the many persons in the lower and middle income groups whose firms and organizations had sought the assistance of insurance companies in providing medical aid for their staffs.

Dr. Adler raised the question of whether the Committee had acted correctly in informing the insurance companies of its recommendations to Council, and after some debate it was proposed by Dr. Wagner, seconded by Dr. Turton, that the action of the Committee be condoned. Before this could be put to the vote, it was proposed by Dr. M. Shapiro, seconded by Dr. Gluckman

that the question be not now put. On this being put to the vote, Council *Resolved* accordingly.

Discussion continued until 12.45 p.m., when Council adjourned for lunch, resuming at 2.20 p.m.

The debate continued, and during the afternoon the following amendments were put forward:

To the first recommendation of the Committee on Medical Insurance: It was proposed by Dr. Paterson, seconded by Dr. Slabbert, that this be amended to read: 'The Medical Association of South Africa will be prepared to cooperate with insurance organizations in order to enable them to provide an adequate service to the public'.

A second amendment was proposed by Dr. L. S. Robertson, seconded by Dr. Chapman, reading: 'That the Medical Association of South Africa agrees to cooperate with insurance organizations which provide prepaid medical care, in order to enable them to provide an adequate medical service to the public'.

After discussion Dr. Paterson and Dr. Slabbert agreed to withdraw their amendment.

The second amendment as proposed by Dr. L. S. Robertson and Dr. Chapman was put to the vote and *Carried Nem. Con.*, 51 votes being recorded in its favour. It was then put as the substantive motion and was *Carried*.

The debate continued until 6.10 p.m., when Dr. L. S. Robertson moved the adjournment. This was *Carried*.

Council adjourned at 6.10 p.m.

FRIDAY 4 MARCH

The Meeting commenced at 9.15 a.m., when Council resumed debate on the second recommendation of the Committee on Medical Insurance and 2 amendments which had been put forward in connection with this recommendation.

The first amendment was proposed by Mr. Currie, seconded by Dr. Purcell and read: 'That Federal Council is prepared to recognize any group which complies with medical aid society rules, whether it is financed by an insurance company or not'.

The second amendment was proposed by Dr. Zabow, seconded by Dr. Helman and read: 'That the preferential tariff as amended from time to time be granted to all groups which can conform with the rules laid down for approval as medical aid societies, on the understanding that the organizations administering them will in their turn undertake to pay the accounts of doctors direct and in full'.

After prolonged debate, the second amendment as proposed by Dr. Zabow and Dr. Helman was put to the vote and *Carried* by 45 votes to 11. Dr. M. Shapiro requested that the names of the members voting for and against the motion be recorded. They were as follows:

For the motion: Drs. Slabbert, Helman, Oates, Paterson, Purcell, Coetzee, Spiro, Penn, Kretzmar, J. H. L. Shapiro, Zabow, Turton, Joubert, Wagner, Struthers, Kuschke, de Beer, Bezuidenhout, Sichel, Whitsitt, Casewell, Chapman, Lawrance, Troskie, Hagen, Currie, Armitage, Lane, M. A. Robertson, Landau, Grundlingh, Albert, Waks, Taylor, Grant-Whyte, Sweetapple, Disler, Mackenzie, Alexander, Rossiter, Theron, Agranat, Louw, L. S. Robertson, Schaffer.

Against the motion: Drs. Gluckman, M. Shapiro, Adler, Broomberg, McMurray, Gillwald, Marr, Heyman, Moller, Girdwood, Radloff.

Dr. Zabow's amendment was then put as the substantive motion and was *Carried* by 45 votes to 12. Dr. M. Shapiro again asked that the names of the members voting for and against the motion be recorded. They were as follows:

For the motion: Drs. Troskie, M. A. Robertson, Albert, Spiro, Penn, Lawrance, Rossiter, Disler, Grant-Whyte, Waks, Mackenzie, Grundlingh, Casewell, Oates, Joubert, Wagner, Turton, Struthers, de Beer, Theron, Taylor, Lane, Kuschke, Hagen, Coetzee, Kretzmar, Sweetapple, Sichel, Bezuidenhout, Whitsitt, Chapman, L. S. Robertson, Agranat, Schaffer, Segall, Louw, Paterson, Armitage, Purcell, Currie, Slabbert, Zabow, Helman, Alexander, J. H. L. Shapiro.

Against the motion: Drs. Gillwald, Heymann, Moller, Girdwood, McMurray, Landau, Radloff, Adler, Gluckman, M. Shapiro, Marr, Broomberg.

The Chairman drew attention to a notice of motion over the names of Dr. Oates and Dr. Paterson which had been included in the Agenda and which had been the subject of an official announcement in the *Journal* of 13 February 1960. The notice of motion read: 'That the decision taken in Minute 47 of the record of the Federal Council Meeting held in Pretoria in October 1958, whereby recognition would be withdrawn from any medical aid society which might become "underwritten by an insurance scheme", be reviewed and rescinded at the next Meeting of Council'. He stated that the rescission now became consequential on the decisions which Council had taken. The motion to rescind was then put to the vote and was *Carried* by 46 votes to 7. Dr. Gluckman asked that his vote be recorded against the motion.

Dr. Lawrance then moved the final recommendation of his Committee as follows: 'That if the recommendation is accepted, the Executive Committee of Federal Council appoint a small sub-committee to thrash out all the details with representatives of the insurance schemes'.

Discussion followed and it was eventually proposed by Dr. Paterson, seconded by Dr. Slabbert, that the motion be now put. On being put to the vote, this proposal was *Carried* by 30 votes to 7.

The recommendation of the Committee on Medical Insurance was thereupon put to the vote and was *Carried* by 22 votes to 10.

Dr. M. Shapiro, seconded by Dr. Gluckman, gave notice of motion: 'That the second resolution taken in the Report of the Committee on Medical Insurance be reviewed and rescinded at the next session of this Meeting of Council, and that the following be substituted: "That this Association agrees to extend to non-profit insurance companies and other non-profit organizations the preferential tariff applicable to medical aid societies, provided (*a*) that such tariff shall be applicable only to insured persons whose incomes fall below certain levels in relation to size of family as determined by the Council, (*b*) that all such conditions shall apply as may be determined by the Federal Council from time to time".'

The Chairman agreed that this receive the attention of Council at the afternoon session.

Dr. Lawrance drew attention to a short addendum to his Report and moved that it be noted. Council *Agreed*.

Dr. Lawrance then proposed that the Report of the Committee on Medical Insurance, as amended, be adopted by Council. Council *Agreed*.

REPORT OF THE EXECUTIVE COMMITTEE

19. *Registration of Optometrists:* The Chairman of the Committee, Dr. Struthers, gave a brief resumé of what had passed in regard to this matter since the last Meeting of Council. He mentioned the setting up of an *ad hoc* committee by the South African Medical and Dental Council and the representations which had been made to the Executive Committee by the Ophthalmological Society. In conclusion he spoke of a recent memorandum which the Executive Committee had received from the Society regarding the practice of orthoptics, and he stated that the Executive Committee had agreed to forward this memorandum to the South African Medical and Dental Council in accordance with a previous decision to pass to the Medical Council all technical memoranda which the Ophthalmological Society might prepare.

Council *Agreed* that the actions of the Executive Committee in this regard be confirmed.

20. *Notes Taken at Council Meetings:* A copy of a letter addressed by the Secretary to the Chairman of Council was submitted and it was reported that the Executive Committee had agreed to recommend to Council 'That the notes of business transacted at Meetings of the Federal Council taken by the Secretary of the Association and from which the Minutes of such Meetings are compiled shall be regarded as confidential, and no extract from or copy of such notes shall be supplied to any member of the Association without the specific sanction of Federal Council'.

An amendment was proposed by Mr. Currie, seconded by Mr. Armitage, that the words 'or its Executive Committee' be added at the end of the Executive Committee's recommendation.

A second amendment was proposed by Dr. M. Shapiro, seconded by Dr. Gluckman, 'That the notes of the Secretary shall be confidential to the members of the Council, on the understanding that the notes are not official or verbatim'. After discussion this amendment was put to the vote and was *Carried* by 30 votes

to 13. It was then put as the substantive motion and was again *Carried*.

Council adjourned for lunch at 12.50 p.m. and resumed at 2.25 p.m.

21. *Medical Insurance—Rescission of Resolution:* The notice of motion proposed by Dr. M. Shapiro, seconded by Dr. Gluckman, was read as follows: 'That the second resolution taken under the Report of the Committee on Medical Insurance be reviewed and rescinded at the next session of this Meeting of Council, and that the following be substituted: "That this Association agrees to extend to non-profit insurance companies and other non-profit organizations the preferential tariff applicable to medical aid societies, provided (*a*) that such tariff shall be applicable only to insured persons whose incomes fall below certain levels in relation to size of family as determined by the Council, (*b*) that all such conditions shall apply as may be determined by the Federal Council from time to time".'

The Chairman stated that he was prepared to take the motion in two parts, as only if the previous resolution was rescinded in terms of the first part, could the second part be placed as a separate motion.

Discussion followed and the Chairman ruled that the vote would be taken by poll.

On being put to the vote, the motion to rescind was *Lost* by 12 votes to 40. There were two spoilt voting papers. Dr. Gluckman asked that the names of the members voting for and against the motion be recorded. They were as follows:

For the motion: Drs. Kretzmar, Girdwood, Broomberg, Zabow, Radloff, Gluckman, J. H. L. Shapiro, M. Shapiro, Adler, Moller, Schneider, Heymann.

Against the motion: Drs. Albert, M. A. Robertson, Segall, Schaffer, Chapman, Agranat, L. S. Robertson, Coetzee, Penn, Spiro, Bezuidenhout, Slabbert, Oates, Helman, Lawrance, Waks, Casewell, Grundlingh, Troskie, Hagen, Kuschke, Grant-Whyte, Mackenzie, Disler, Marr, Landau, Lane, McMurray, Struthers, Turton, Wagner, Joubert, Whitsitt, Sichel, Armitage, Purcell, Currie, Paterson, Theron, Louw.

REPORT OF EXECUTIVE COMMITTEE (CONTINUED)

22. *O.F.S. Goldfields Branch:* It was reported that this Branch was now established and was represented at the present Meeting of Council. *Noted.*

23. *Staff Superannuation Fund:* It was reported that in accordance with the previous resolution of Council the Executive Committee had considered this matter and had agreed to recommend to Council—

(*a*) That the pension age in the Association's service be raised from 60 to 65 for men and from 55 to 60 for women.

(*b*) That the sliding scale of pension contributions, based on length of service, be introduced as from 1 January 1960 in accordance with the proposals of the South African Mutual Life Assurance Society, viz. 5% each for the employee and the Association up to 5 years' membership of the Fund, 7½% each over 5 years up to 10 years' membership of the Fund, and 10% each for those of over 10 years' membership of the Fund.

It was proposed by Dr. Paterson, seconded by Dr. Purcell and *Resolved Nem. Con.* that the recommendations of the Executive Committee be adopted.

24. *Emoluments of Business Manager:* It was reported that in accordance with an earlier resolution of Council, the Executive Committee had considered this matter and had agreed to recommend to Council that a personal allowance of £200 *per annum* be paid to the Business Manager as from 1 January 1960.

It was proposed by Dr. L. S. Robertson, seconded by Dr. Alexander and *Resolved Nem. Con.* that the recommendation of the Executive Committee be *Adopted.*

25. *Sale of 'Byrness':* It was reported that the property had been for sale for some time with a reserve price of £7,500 placed on it. The highest offer received up to the time of the Executive Committee meeting in December had been £5,500. After giving the matter consideration at that time, the Executive Committee had agreed to withdraw the property from sale. After it had been withdrawn, a further offer of £6,000 had been made. The Executive Committee considered that the Council should decide as to whether the property should be finally sold.

After discussion it was proposed by Mr. Joubert, seconded by Dr. Turton, that the property 'Byrness' be sold at the figure of £6,000.

An amendment was proposed by Dr. M. Shapiro, seconded by Dr. J. H. L. Shapiro, that the house be sold by private treaty with a reserve of £6,000.

On being put to the vote, the amendment was *Carried* by 29 votes to 3. It was then put as the substantive motion and was *Carried Nem. Con.*

Council further *Resolved* that the present occupant of the house be given the first option to purchase the property at the reserve price.

26. *Election of Vice-Presidents:* It was reported that the Executive Committee had considered the question of the appointment of Vice-Presidents of the Association as a means of honouring certain of its members who had rendered exceptional service to the Association, and that it had agreed to recommend to Council that Honorary Vice-Presidents be elected immediately under By-law 51. Council *Resolved* accordingly.

It was reported further that consequent upon the acceptance by Council of the above recommendation, the Committee recommended to Council that the honour of Honorary Vice-President be conferred on Dr. A. J. Orenstein, Dr. J. H. Harvey Pirie and Dr. A. W. S. Sichel. Council *Resolved* accordingly, amid acclamation.

27. *Appointment of Delegates:* It was reported that the Executive Committee had agreed to appoint Dr. P. F. H. Wagner, President of the Association, to be its official delegate to the Annual Meeting of the British Medical Association to be held at Torquay from 20 to 24 June 1960. *Noted.*

It was further reported that the Committee had agreed that Dr. Emilia Krause be appointed to represent the Association at the 14th General Assembly of the World Medical Association to be held in Berlin from 16 to 21 September 1960. *Noted.*

28. *Appointment of New Committees of Council:* The Chairman explained that he had discussed with the Executive Committee the appointment of certain new Committees of Council to look after the special interests of general practitioners, specialists and full-time medical officers. The Executive Committee had resolved as follows: 'That, having considered the suggestion of the Chairman of Council that 3 new Standing Committees of Council be formed to promote the interests of the general practitioners, specialists and full-time medical officers, the Committee recommends to Council that this question be considered further by the Executive Committee and that a report be made to Federal Council at a later date'. Council *Resolved* accordingly.

29. *Circulation of Minutes:* The Chairman stated that the Executive Committee had considered the question of the circulation of the minutes of Committee meetings, and said that he felt that the circulation of information contained in unconfirmed Minutes amongst members who had no knowledge of the background might cause difficulty. As a result the Executive Committee had agreed to recommend to Council 'That it be a directive to all members of Council that the minutes of Committees of Council, or any other documents relating to the work of Council Committees, which are circulated to Federal Councillors between Meetings, are to be treated as confidential documents until they have been received and discussed by Council, and in no circumstances shall the contents of such documents be divulged to non-members of Council'.

Discussion followed, during which it was suggested that the minutes of Committees which were circulated to members of Council should bear a rubber stamp reading 'Confidential to Federal Councillors'. Finally Council *Agreed* that such a rubber stamp should be prepared and used to endorse the first page of all Committee minutes.

30. *Registration of Medical Technologists:* The Chairman reported on the actions of the *ad hoc* committee appointed by the South African Medical and Dental Council to deal with this matter.

Dr. M. Shapiro raised the question of the registration of those persons who had been practising medical technology for some years, and stated that the regulations were at present in the hands of the Minister of Health before they were promulgated. At the request of the Chairman, Council *Agreed* that the matter be referred to the Parliamentary Committee.

31. *Governmental Commission of Enquiry into High Costs of Medical Services and Medicines:* A memorandum containing the relevant Government Notice and the terms of reference of the Commission of Enquiry was submitted, together with a copy

of a letter from the Chairman of the Commission and a report to date.

The Secretary stated that the Branches had received a circular inviting them to prepare and submit memoranda under 5 headings as suggested by the Chairman of Council. The Executive Committee had agreed that the memoranda so submitted should be correlated by the Secretaries of the Association and suitably amplified for submission to the Commission as the basis of the Association's evidence.

Dr. Troskie reported on certain resolutions which had been taken by the O.F.S. and Basutoland Branch, which the Deputy Chairman stated would be noted.

A recommendation to Council from the Executive Committee, reading 'That relevant information be obtained from the Branches and correlated by the Secretaries for the Committee of the Association appointed to present evidence to the Commission of Enquiry', was put to the vote and was *Carried*.

A resolution proposed by Dr. Troskie and seconded by Dr. Kuschke, reading 'Dat die Vereniging onmiddellik 'n vraelys uitstuur aan sy lede om pertinente feite rakende hierdie ondersoek in te win', was also put to the vote and *Carried*.

It was further proposed by Dr. Waks, seconded by Mr. Joubert and *Resolved Nem. Con.*, 'That in view of the difficulties facing the Association relative to the type of evidence which the Commission may require, the Commission be approached and be asked to give the Association a lead on the form of evidence it would wish the Association to present'.

(To be continued)

PHARMACEUTICAL NEWS: FARMASEUTIESE NUUS

Since this issue of the *Journal* is published with the intention of contributing in some small part to the celebration of the Union Festival, the Editorial Board felt that it would be suitable to approach some of the ethical firms, which have been active in the pharmaceutical field in this country for many years, with a request to contribute articles for publication in the *Journal*, dealing with the history and objectives of their firms. We also wish to record our great indebtedness to all the other firms, who, through the years, have supported the *Journal* and made its publication possible.

BURROUGHS WELLCOME AND CO.

Burroughs Wellcome and Co. was established in Cape Town in 1902. For many years before this, however, the parent company had been active in Southern Africa, commencing shortly after two young American pharmacists, S. M. Burroughs and Henry S. Wellcome had founded the partnership of Burroughs Wellcome and Co., in London in 1880. Wellcome (later Sir Henry Wellcome), through mutual friends among African travellers, became a close friend and admirer of the famous explorer, Sir H. M. Stanley, and developed a profound and lasting interest in the continent of Africa.

Of the many distinctive insignia which have carried the reputation of British goods into every part of the world, few are better known than the unicorn emblem which identifies the pharmaceutical products of Burroughs Wellcome and Co. Printed on labels and in literature and advertisements, embossed on bottle-caps, outlined in gold on showsigns or sculptured in silver on exhibition stands, the 'B.W. & Co.' unicorn has become a familiar symbol of scientific pharmacy wherever medicinal and veterinary products are used.

The name of Burroughs Wellcome and Co., stands for a record of industrial and scientific achievement which, crowded into the 70 years of the company's existence, forms a fascinating chapter in the histories both of commerce and medical development.

After the death of Burroughs in 1895, Burroughs Wellcome and Co., became a one-man undertaking under the sole proprietorship of Henry Wellcome. It was obvious to Wellcome that firms such as his must carry out scientific research in their own laboratories—then a new conception, but now generally accepted in the pharmaceutical industry. As a result there came into being a group of scientific laboratories and institutions additional to those immediately concerned with routine production matters, and devoted to fundamental research in the medical sciences.

One of the earliest achievements of Burroughs Wellcome and Co., in making a new therapeutic agent available for clinical use, originated in Africa. Recognizing the important clinical possibilities of strophanthus, then known only as an African arrow poison, Wellcome sent an agent to the Kombé region of East Africa to purchase authentic material from the native chiefs. This led in due course to the isolation of Strophanthin K (an interesting analogous research project is the much more recent introduction of 'Tubarine', a muscle relaxant isolated from curare, an ancient American arrow poison).

The cardiac glycosides and other cardiovascular drugs have since featured prominently in the research activities of the Wellcome Laboratories. 'Diginutin' from *Digitalis purpurea* was made available in 1929 and digozin ('Lanoxin') from *Digitalis lanata* in 1933. The outstanding advantages of 'Lanoxin' have since received endorsement by its inclusion in the British Pharmacopoeia 1948 and the 13th version of the USP. The most recent contribution in the cardiovascular field has been the introduction, in 1959, of 'Darenthin' (bretylium tosylate) acknowledged as a fundamental advance in the treatment of hypertension.

Wellcome research has been active in many other departments, notably biological research leading to the production of vaccines against diphtheria, tetanus, whooping cough, etc. Equally notable results have been achieved in the control of animal diseases. Ever since Wellcome's early personal interest, research on tropical diseases has received much attention and the resulting products for the treatment and prevention of malaria ('Daraprim' and 'Daraclor'), schistosomicides ('Nilodin' and 'Triostam'), etc., have had particular application in Southern Africa.

In 1924, the administration of Burroughs Wellcome and Co., and of the many scientific establishments, museums and libraries founded by Sir Henry Wellcome was unified by the registration of The Wellcome Foundation Limited, as a private limited liability company. Sir Henry Wellcome died in 1936 and under his will, the trustees of the Wellcome Trust devote all surplus revenues of The Wellcome Foundation Limited to the advancement of research work in medicine and veterinary and allied subjects. The company thus represents a unique example of a commercial enterprise dedicated solely to the prevention, alleviation and cure of disease. There is no exact parallel to the entire use of a commercial firm's day-to-day profits for charitable purposes.

Sir Henry Wellcome in his long life saw many changes in medical science—from his boyhood amongst the American Indians where on occasion he helped to fight off Sioux raiders and assist his Uncle Jacob, a frontier surgeon, to his founding of a Trust which is unique, but it is doubtful whether they equal the changes that have taken place in the quarter century since his death. Today his Foundation is spending over a million pounds *per annum* on research, a quarter of the total amount spent by the whole of the British pharmaceutical industry; and additional to this the Second Report of the Wellcome Trustees, published recently, shows how wide and diverse are the research projects supported from the dividends of his Foundation.

On 8 December 1843, William Brockedon, the inventor of compressed tablets, was granted English Patent No. 9977 for 'Shaping Pills, Lozenges and Black Lead by Pressure in Dies'. The patent rights in the Brockedon apparatus for making compressed products were acquired by Burroughs Wellcome and Co., and in 1884 the trade mark 'Tabloid' was registered. 'Tabloid' medical cases, which included surgical dressings as well as compressed products, were carried by every notable explorer of recent times. They accompanied Livingstone and Stanley on their African expeditions and both Scott and Amundsen on their South Polar expeditions.

The South African War gave a great impetus to medicine in South Africa. Sir Henry Wellcome was active in alleviating the suffering of the conflict. In conjunction with Lady Randolph (Sir Winston Churchill's mother) he was responsible for equipping the hospital ship, Maine. The increased demand for the Company's biological and other pharmaceuticals lead to the establishment of the South African Company in 1902 in Cape Town.

Older than Union, the company traded from 5 Loop Street until 1960, when it entered into arrangements with its associated company Cooper and Nephews (S.A.) Ltd., for a joint depot at Maitland.

With the movement in population from the coast to the Reef, the head office of the company was moved to Johannesburg in January 1956. On 1 December 1959 a modern factory was opened in Johannesburg. Burroughs Wellcome and Company (South Africa) Ltd., whose own expansion in South Africa parallels the dramatic development of the Union itself, is proud of the fact that its products are now 'Made in South Africa'.

JOHNSON AND JOHNSON (PTY.) LTD.

Since the conception of the firm of Johnson and Johnson its growth and progress have been dramatic, and the products they present to the medical and pharmaceutical professions throughout the world are well known and readily acceptable.

Johnson and Johnson was formed by a young Scotsman, Robert Wood Johnson, in 1874. Johnson was then associated with the medical and pharmaceutical professions of America and he established his first plant and laboratories in New Brunswick, New Jersey, USA. This plant consisted of a small building covering approximately 17,000 sq. ft. and employed 14 people. On the death of its founder, the Johnson and Johnson organization was taken over by his son, General Robert Wood Johnson, who is now Chairman of the whole group of Johnson and Johnson Companies and their associates throughout the world.

The following figures, as at the end of 1959, illustrate the importance of this organization: Employees throughout the world: 30,000 (approx.); value of manufacturing and laboratory facilities: £40,000,000 (approx.); and sales of products throughout the world: £140,000,000 (approx.). These figures prove that confidence is shown in the products evolved, produced, and distributed by Johnson and Johnson.

The principal reason for Johnson founding the Company in 1874 was to make available to the medical profession surgical dressings, surgical plaster, surgical ligatures, surgical specialities, and orthopaedic specialities of an aseptic nature conforming to the findings of Pasteur and the application of these findings by Lister. In following the technique of these renowned scientists, Johnson produced aseptic dressings for which there was and still is a great demand, and which have placed Johnson and Johnson in a premier position in world development and manufacture of these essentials to modern surgery. The position of Johnson and Johnson today has only been brought about by the close cooperation of the medical profession and its associates, and through the intensive and costly research carried out by Johnson and Johnson.

During the First World War Johnson's specialities were in great demand by the Allies, and at the termination of hostilities Johnson and Johnson decided to extend their activities outside North America. They adopted the policy of making their products available in every country in the world and, with this policy in mind, opened branch offices for distribution, manufacture and research, taking full advantage of local labour conditions and supplies.

Johnson and Johnson, South Africa

Although Johnson and Johnson products have been available in South Africa for 50 years, it was not until 1930 that the opportunity occurred to establish a South African organization for manufacturing, distributing, etc. This newly established company enjoyed the same success as its parent company and has today, established a most modern factory in East London. Following the parent company's policy it is the South African company's intention to produce, within the resources of South Africa, all lines possible. Products which are not at present produced in South Africa are however still available from overseas.

Associate companies of Johnson and Johnson have always been conscious that an organization such as theirs may become unwieldy to manage, and therefore the policy which has been adopted is that as soon as a product enjoys a substantial demand and usage from the professions, a separate company is formed, whose duty it is to specialize in all research work, development, manufacture, and distribution of that product. For example, surgical ligatures, which many years ago were manufactured by Johnson and Johnson, received such a demand that a separate organization which could specialize entirely in the development of this important surgical necessity was warranted; Ethicon Incorporate was therefore formed. This policy also applies to the following list of subsidiaries: Ortho Pharmaceutical (gynaecological products and blood diagnostic sera); Ethicon Incorporated (suture materials and allied products); Permacel Tape Corporation (industrial tape, cloth and cellulose); Personal Products (Modess, Meds, tissues and Modess belts); Chicopee Manufacturing Corporation (Masslinn non-woven fabric, Saran); Tek-Hughes Incorporated (brushware); McNeil Laboratories Inc. (therapeutic products); and Cilag Chemie (therapeutic products). These companies are responsible to a central board in America, but operate independently and in turn have their own subsidiary companies throughout the world. An important point, however, is that they are all controlled by the Central Quality Control Board of America, who have the best facilities for research and exchange of information for the improvement of any product throughout the whole organization. This research and improvement is constantly carried out, together with frequent visits of personnel, etc.

Johnson and Johnson, South Africa, are also very active in the toilet and pharmaceutical fields and for convenience-sake they distribute their highly specialized dressings and ethical products through a wholly-owned subsidiary company, Ethical Products (Pty.) Ltd., the Ethical Division of Johnson and Johnson (Pty.) Ltd., South Africa. A well-trained and competent force of medical representatives cover South Africa and the Central African Federation and make available to the profession the latest developments in the Johnson and Johnson specialities.

BRITISH DRUG HOUSES LIMITED

The pharmaceutical and fine chemical industry as we know it today is largely a product of the 20th century although, as is the case with British Drug Houses Ltd., its roots are set in the drug warehouses and medical halls of earlier years.

The life of the present company commenced 52 years ago, but the first step towards the combination was taken in 1897 when A. S. Hill and Son and Davy Yates and Hicks amalgamated under the name Davy Hill and Company. In 1906 the business of Hodgkinsons, Clarke and Ward was added to form a company under the title Davy Hill and Hodgkinsons Limited. Two years later with the further addition of the businesses of Barron, Harveys and Co. and Hearon, Squire and Francis Ltd. there came into being British Drug Houses Ltd. with a capital of £200,000. A 6th constituent was added when George Curling, Wyman and Company Ltd. was incorporated within the structure in 1919.

It is interesting to recall that one of the participating businesses, that of Hearon, Squire and Francis, could trace its history from as far back as 1714 and each of the others was established before the close of the 18th century—Barron, Harvey and Co. (1750), A. S. Hill and Son (1755), Davy Yates and Hicks (1760), Hodgkinsons, Clarke and Ward (1762), and George Curling, Wyman and Company Ltd. (1798). The architect of the new enterprise was Mr. Charles Alexander Hill, B.Sc., F.I.C., who saw in the combination of the knowledge, craftmanship, integrity and wide commercial experience of the participating companies a structure with resources and potential hitherto undreamed of in the pharmaceutical world.

Mr. Hill continued as chairman and managing director of BDH until his retirement in 1943 and the steady progress of the company over the past 52 years and the strong position it holds in the industry today are in no small measure a testimony to his foresight and organizing ability.

The original offices, laboratories and warehouses were established on a site of some 2½ acres in Graham Street, London, and this location remains to the present day the administrative centre for the company's world-wide activities. Considerable additions have been made in succeeding years and the area now covered is approximately 5½ acres.

The capacity of these premises has long since proved inadequate for the company's growing production and warehousing requirements and the need for expansion has resulted in the acquisition of additional properties at Kensal Road, London (packing and warehousing); Godalming, Surrey (research laboratories and basic chemical manufacture); Poole, Dorset (laboratory reagent and fine chemical manufacture); and Liverpool and Nottingham (distributing depots).

As will be recognized, the life of 'BDH'—the abbreviation by which the company has become universally known—has run concurrently with the most momentous years in pharmacy and

medicine and an examination of its price lists over the years clearly reveals the vast changes which have taken place both in manufacturing and retail pharmacy in this comparatively short period of time.

At its inception the company planned to make available a range of the traditional pharmaceutical merchandise—drugs, galenicals and packed goods—in quantity and of such a high standard of uniformity only achievable by the application of the most rigid methods of production control then known. The realization of this objective depended greatly on effective analytical control and so there was initiated the system of analytical supervision which has ever since been at the heart of BDH production. The need for such supervision was, in those early years, very real indeed. Essential oils in particular were often found to contain artificial esters and turpentine, and some crude drugs were grossly sophisticated as, for example, storax containing only about 5% of balsamic acids, powdered drugs adulterated with ground olive stones, and balsam of tolu partially exhausted. These and many other hazards beset the unwary purchaser and BDH analysts sought to remove them. The habits of suppliers are in these days more responsible but the need for analytical vigilance is no less vital.

As more complex organic chemicals have been introduced into pharmacy, the tools of analytical control have become correspondingly complex and so the pipettes and burettes of earlier years are now ranged alongside such laboratory aids as ultra-violet and infra-red absorption spectrophotometers and apparatus for gas chromatography. More than 100 graduates and technicians are engaged in analytical control alone.

Success in the field of pharmaceutical manufacture however demands more than that its products shall be carefully and accurately made and tested. It also demands foresight and enthusiasm for investigation—in short, it demands research—and to this end the BDH Research Laboratories were established. The work of these laboratories has been a vital factor in the company's development of new substances for therapeutic use, and BDH research workers have contributed extensively to scientific literature.

An early achievement was the production of vitamins on a commercial scale and the national press at the time paid tribute. Standardized BDH vitamin preparations are in regular clinical use to the present day and such names as Multivite, Multivite Forte, Radio-Malt, Radiostol, Radiostoleum, and Radiomulsin are known to millions of people in many parts of the world. BDH was also one of the initial producers of insulin in Great Britain.

The study of methods of liver extraction and the development of a specialized plant for large-scale production were followed by the introduction of Anahaemin for the treatment of pernicious anaemia, a product which has been widely used by the medical profession for more than 20 years.

Doctors and pharmacists will need no reminder of the company's association with the development of synthetic steroidal hormones. The investigations of its workers in this branch of research have been unceasing and the recent introduction of tablets of dimethisterone under the trade mark 'Secrosteron' was a notable advance and also the first all-British discovery in this field. Secrosteron is a purely progestational agent.

The first non-nitrogenous muscle relaxant, mephenesin, the active substance of Myanesin preparations, came from BDH research and from the same avenue of studies also came chlorphenesin, widely acclaimed as a most effective fungicide and the basis of Mycil Powder and Ointment. From the study of heterocyclic compounds came meclozine hydrochloride a successful antihistaminic and remedy for travel sickness, introduced to the medical profession as 'Ancolan' tablets. An entirely new form of cough suppressant, oxeladin citrate, has been made available as Pectamol Cough Linctus and Pectamol Cough Pastilles.

Recently, recognizing the stability of aluminium hydroxide-magnesium carbonate co-dried gel throughout the process of drying and tabletting, and its consequent superiority to the official preparation aluminium hydroxide gel BPC, the company introduced Almacarb tablets (shortly to be marketed in the Union under the trade name of Neutrate Tablets). As a result, the medical profession will have available a convenient and effective antacid preparation which is known to retain its neutralizing potential even during prolonged periods of storage.

It is a long-standing policy of the British company that doctors and pharmacists shall have available through the BDH a range of medical products, drugs and galenicals of the most comprehensive nature. That this policy has popular approval has been abundantly demonstrated over the years by continuous requests that the company should include within the framework of its service the distribution of the products of other manufacture in addition to the BDH range. With a country-wide distribution system probably unique within the industry, such an enterprise was both possible and practical. Today, the ethical and proprietary products of the principal pharmaceutical manufacturers are distributed by BDH vans in many areas in Great Britain. To further strengthen its distribution facilities the company has recently acquired the controlling interest in two well-known and long established businesses engaged in wholesale distribution—Rowland James Ltd., of Cardiff and Swansea, and J. R. Gibbs Ltd., of Paignton, who also held the controlling interest in Ferris & Co. Ltd., of Bristol.

For many years BDH has been widely known also for its laboratory reagents and fine chemicals for specialized industrial uses. The company's interest in this field may be said to have commenced at the outbreak of the First World War when, as the result of the cessation of supplies from continental manufacturers, BDH was asked by His Majesty's Government to take steps to make provision for the supply of reagent chemicals to meet the needs of the armanent and other industries. The demands for these chemicals grew rapidly and soon their excellent qualities became recognized by scientific workers of every kind, both industrial and academic. By 1939 the company was one of the world's foremost producers of this class of materials. Long before the cessation of the Second World War it was clear that the continually expanding demands could not be met by the existing plant in London, and so in 1946 new premises were acquired at Poole, Dorset. Here a new unit, known as the BDH Laboratory Chemicals Division, was set up with its own office and sales organization. Its products include organic and inorganic fine chemicals, analytical reagents, chemical indicators and microscopical stains, amino acids and chemicals of reagent quality with wide industrial applications. The usage of these chemicals expands at an ever increasing pace as more industrialists come to appreciate the saving in time and money which can be effected by the use of specially pure chemicals—BDH Laboratory Chemicals and industrial chemicals of laboratory purity. So rapid has been the advance that the original factory at Poole is no longer adequate and an extensive building programme on an entirely new site has already been commenced.

Overseas there are BDH laboratories and works in Canada and India and associated companies in South Africa, Australia, New Zealand, Malaya and Eire. Elsewhere, in upwards of 90 countries, there are appointed agents and distributors.

Although this article on the history of the BDH has, of necessity, dealt mainly with the parent company, plans are constantly being prepared for the development of the subsidiary companies. It is therefore pleasing to record that an ambitious programme for the further expansion and development of BDH South Africa has just been approved.

MAY AND BAKER LIMITED

The origin of May and Baker Limited forms part of a chapter of interesting history. Towards the close of the 18th century, John Whitmore Baker, a landowner and sheep-farmer of Dedham Hall, Essex, England, sent his two sons to the market town of Chelmsford, William as an apothecary, Samuel as a veterinary surgeon. William married, and his son William Garrad Baker, co-founder of the present company, was born in 1815.

John May, born in Ipswich and apprenticed to a local apothecary, was William Baker's senior by 7 years. On completion of his studies, and after gaining manufacturing experience with the firm of Charles John Price in Battersea, London, he started business on his own in the same district in 1834. Five years later he was joined by William Garrad Baker and for 37 years they controlled alone the destinies of their company. May died in 1893, and his co-founder 9 years later.

On sound foundations, progress continued in Battersea, and in 1934 development of the May and Baker organization was such that space for expansion became necessary. A move was then made to Dagenham, Essex, thus renewing associations with the county some 100 years after the founders had journeyed in the opposite direction to establish the enterprise.

Marked developments have been witnessed since the days when the company's activities comprised the manufacture of sodium and potassium cyanides, chloroform, mercurials, and bismuth salts. In 1938 the advent of sulphapyridine—'M & B 693'—represented one of the most outstanding chemotherapeutic advances of the age. This product, the outcome of intensive investigations in the May and Baker laboratories at Dagenham, was in itself a complete justification of the policy of research to which the company had long been committed.

Since 1938 the company has been associated with the development of new drugs including sulphathiazole, ethopropazine, promethazine, chlorpromazine, prochlorperazine, trimeprazine, pentolinium and pempidine. Constructional work on a new research institute at Dagenham is nearing completion and it is expected the buildings will be equipped and in full operation soon after June of this year.

The M & B Research Institute will comprise 3 main buildings: a chemical wing, a central building housing the library, lecture theatre and administrative offices, and a biological wing with ancillary buildings. The entire block will provide over 100,000 square feet of floor space at a cost of over £1,000,000.

This new Research Institute will enable existing research units from various laboratories in the Dagenham works to be brought together in one coherent group. At the same time it will provide additional facilities for scientists working on expanded research programmes. Close liaison with the company's present agricultural and veterinary research station at Ongar, some 12 miles from the main Dagenham works, will be continued and, later, there will be further development of this field research station.

In addition to the Dagenham works there is another undertaking at Norwich which is growing in size each year. Associated overseas manufacturing plants and laboratories have been established in India, Pakistan, Australia and in South Africa.

Production at the Port Elizabeth factory of Maybaker (S.A.) (Pty.) Ltd., commenced in 1948, since when expansion of the buildings and plant has taken place at a steady rate. Today the factory is manufacturing the majority of the medical and veterinary specialities bearing the trade-mark of 'M & B'. The high quality of the products is maintained by means of a fully equipped control laboratory which checks each batch of tablets, solutions, and other preparations against standard specifications. Wherever possible, raw materials of South African origin are favoured and the company is staffed mainly with South African citizens.

WESTDENE PRODUCTS (PTY.) LTD.

On 3 October 1923 a small retail chemist shop opened it's doors at 116a, Zastron Street, Bloemfontein. It was in the new suburb of Westdene and was appropriately named The Westdene Pharmacy. The staff consisted of its founder, Mr. A. M. Reichenberg and one delivery boy. As business was brisk, his brother, Mr. L. H. Reichenberg, joined him 2 weeks later.

In 1926 an opportunity presented itself for national development by the acquisition of the agency for Transpulmin, Treupel Tablets, Nohaesa, Kamillosan, Spirobismol, etc. This necessitated Union-wide travel by Mr. L. H. Reichenberg to introduce these products to the doctors. Most of the doctors in those days said quite bluntly that they knew how to write prescriptions and had no need for these 'new-fangled concoctions which might be of interest to youngsters who could not prescribe'. Pneumonia and venereal disease were still formidable.

In 1927 Westdene Pharmacy was appointed 'special' wholesalers by the agents of Beiersdorf, Hoechst, Bayer, Genatosan and Merck. The selling arrangement (relinquished in 1931) was that Mr. L. H. Reichenberg devoted half of his time to these products and received a retainer fee of £15 0s. 0d. per month and 15s. per working day. This made it possible to do more intensive travelling, so it was found necessary to call on the services of Mr. J. Reichenberg, the father of the two Reichenberg brothers, to take charge of the accounting side of the business. Shortly afterwards, Mr. G. Reichenberg, their youngest brother, joined the firm and was trained as a traveller (ethical detail men were as yet not produced).

At the time of the depression, Westdene represented Medical Biological Laboratories Limited of London (Antipeol and Enterofagos), Luitpold Werk, and C. H. Boehringer and had already started the manufacture of Tussamag. By the time the depression had ended, Westdene was thoroughly entrenched and had added E. H. Spicer and Company (Serocalcin) to the list of firms they represented.

In 1934 Westdene Products (Pty.) Limited was formed, as it was found that the old name did not describe the full ramifications of the firm, which at that time traded as retail and wholesale chemists and national distributors of pharmaceutical specialities and surgical sundries. The first directors were L. H. Reichenberg, Chairman; A. M. Reichenberg, Managing Director and J. Reichenberg, Director and Secretary.

In about 1936 a depot was opened in Cape Town and after several changes in position and management, it became a full-time branch. In 1939 a Johannesburg branch was opened at 60 Essanby House. At the outbreak of the War, the outlook was indeed bleak. The main European agencies ceased to exist, Britain was hard-pressed to supply, and the new American agencies, i.e. McNeil, Welch Allyn, and the United States Catheter and Instrument Company, had not yet been developed. When recruiting started, 4 members of the firm joined up, which made further development difficult.

By the end of 1940 the bulk of business centred around Johannesburg and Pretoria, so it became necessary to move the wholesaling and agency sections to Johannesburg, and Mr. A. M. Reichenberg was left behind in Bloemfontein to manage the retail business and supply the Bloemfontein requirements of our products. A complete move was made in January 1941, this time to 22 - 24 Essanby House.

In 1944 the retail pharmacy was sold and the Bloemfontein depot closed down. In 1946 the Medical Book Department was opened. The Durban branch was opened during the War and is now housed in National Mutual Buildings. In 1947 the Pretoria branch was opened by our Pretoria representative, Mr. V. G. Nugent, who is now Surgical Sales Manager, stationed in Johannesburg.

In 1948, E. Grieshaber, of Switzerland, who is famous for ophthalmic instruments, asked Westdene to look after his interests in South Africa. This required the development of an ophthalmic department. Other agencies in this field followed—amongst which are Haag-Streit, Hamblin, Clement Clark, Curry & Paxton and R. Toury, of Paris.

In 1950 the firm was appointed distributors for S. Maw Son & Sons Limited of Barnet, England's largest chemist sundries house, and with that agency came the delightful and well-known Mr. E. Norman Torry, who, although now well on in years, is still active. On 1 April 1960 his son, Max, after a period of 10 years in England, joined us and is now is his father's department. He is no doubt known to many doctors who saw active service; Staff-Sergeant Max Torry, SAMC, Roberts Heights, etc.

In 1951 the Upjohn agency was acquired and built up so successfully that in 1958 it became possible for them to form their own Company—Tuco (Pty.) Limited—the Managing Director, typists and 6 detail men were all from Westdene. They continued to distribute Upjohn Products for Tuco until the end of March 1960.

In 1953, to celebrate its 30th anniversary, the Directors gave recognition to long and loyal service by appointing, as full directors, Lothar Frankel, who joined the firm in 1939, and Andries Daniel Kruger, who joined in 1935 and as alternate directors E. D. Cronin, V. G. Nugent, A. Stern and J. L. Rubin, sales managers of ethical, surgical and general departments and administrative manager, respectively. At that time the firm of Dr. A. Wander, of Switzerland, was added to the list of firms represented by Westdene.

In 1953 it was decided to award bursaries of £100 each to a medical student in the 4th, 5th and 6th years at each of the medical schools in the Union, i.e. 3 to each school. At that time Natal was not eligible, as they had no 4th year students, the first award being given in 1955, and they now have the full quota. Stellenbosch has 2 bursaries and will reach maturity next year.

To the nursing profession there is a bursary of £200 *per annum* awarded to a qualified nurse for research or study which can be of benefit to the profession. The second bursar went overseas,

took up journalism, and has since become the Editor of the *South African Nursing Journal*.

The pharmaceutical bursary of £200 *per annum* granted to qualified pharmacists is to be used for investigation, research or study for the benefit of the pharmaceutical profession and the first grant was devoted to a study of pharmacy in South Africa since the time of Van Riebeeck. This is now in the course of publication. The number of bursaries which have been awarded to members of the 3 professions now amounts to 103.

In 1956 Westdene was appointed preferred importers of the instruments of Down Bros., Mayer & Phelps and in 1960 they were appointed sole distributors.

Mr. J. L. Rubin was appointed a full director of Westdene in 1958. In 1958 Mr. H. O. Evans, formerly Sales Manager of Parke, Davis Company took over the position vacated by Mr. E. D. Cronin and was appointed an alternate director in 1959.

New agencies acquired by Westdene in the last few years are: Mer-National Laboratories (Pty.) Limited, Calmic Limited, British Schering Limited, West Pharmaceuticals Limited, Chemway International, AB Bofors, Astra International, William R. Warne Limited, and Telco, of Paris.

Westdene Products distributes commodities manufactured in South Africa, Britain, Canada, Belgium, France, Scandinavia, Switzerland, and the USA and now markets a very wide variety of goods of interest to doctors, nurses, hospitals, chemists, and veterinarians. These goods cover ethical pharmaceutical preparations, surgical instruments, hospital equipment, medical books and journals, hearing aids, Alpa 35 mm. cameras and medical accessories, the very latest instruments and equipment for cardiac surgery, heart-lung machines, and electronic medical and surgical survey units. They are also instrumental in having defibrillators, pacemakers and De Bakey type pumps built in South Africa.

Westdene is now housed on 4 floors at Essanby House and 2 floors at Feltex House, in Johannesburg, and have branches at Pretoria, Durban and Cape Town. They have resident representatives in Bloemfontein and Port Elizabeth, and working arrangements in South West Africa and the Rhodesias. The total staff consists of 160 people and each department has been developed to specialize in its respective sphere. Thus, patients sent in to the hearing-aid department will receive the same meticulous care in the fitting and choice of a hearing aid as can be expected in any part of the world. In the medical book department Westdene have been told by doctors, who have travelled widely, that they have come across no better selection of books anywhere in their travels.

A new department, which is developing rapidly, investigates and distributes products for the control of bacteria in the food processing and canning industry, and the purification of water.

PASSING EVENTS : IN DIE VERBYGAAN

Dr. Basil Solomon, M.B., Ch.B. (Cape Town), F.F.A.R.C.S. (Eng.), D.A. (Eng.), recently of the University College Hospital and the Hospital for Sick Children, Great Ormond Street, London, has joined Dr. Cecil Moss in practice as a specialist anaesthetist at 612 Medical Centre, Heerengracht, Cape Town. Telephones: Rooms 2-1528, 3-1331, residence 69-3890, if no reply 69-2924.

Dr. Basil Solomon, M.B., Ch.B. (Cape Town), F.F.A.R.C.S. (Eng.), D.A. (Eng.), voorheen van die ‚University College Hospital' en die ‚Hospital for Sick Children', Great Ormondstraat, Londen, het nou as 'n spesialis narkotiseur begin praktiseer in vennootskap met dr. Cecil Moss te Mediese Sentrum 612, Heerengracht, Kaapstad. Telefone: Spreekkamer 2-1528, 3-1331, woning 69-3890, indien geen antwoord 69-2924.

* * *

Dr. Louis Hirsowitz, accompanied by his wife, *Dr. F. Segal*, has left Johannesburg for a 3-month overseas visit. Drs. Hirsowitz and Segal will undertake postgraduate study in England and on the Continent while they are away and hope to return to South Africa at the end of July.

* * *

Mr. Jack Penn, F.R.C.S., of Johannesburg, and *Mr. Pierre Hugo, M.Ch.*, of Pretoria, plastic surgeons, will practice in partnership as from 1 June 1960, at Clarendon Centre, Clarendon Place, 4 Park Lane, Parktown, Johannesburg, telephone 44-9587. Mr. Hugo will continue to be available for consultation by appointment at his old address—50 Van Riebeek Medical Building, Pretoria, telephone 30764.

Dr. Jack Penn, F.R.C.S., van Johannesburg, en *dr. Pierre Hugo, M.Ch.*, plastiese chirurge, sal in vennootskap praktiseer vanaf 1 Junie 1960 te Clarendon Centre, Clarendon Place, Parklaan 4, Parktown, Johannesburg, telefoon 44-9587. Dr. Hugo sal nog by sy huidige adres, Van Riebeek Mediese-gebou 50, Pretoria, beskikbaar wees vir konsultasie volgens afspraak, telefoon 30764.

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South African Institute for Medical Research, Johannesburg, Staff Scientific Meeting. The next meeting will be held on Monday 30 May at 5.10 p.m. in the Institute Lecture Theatre. Dr. C. G. Anderson will speak on 'Electrophoresis'.

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University of Cape Town and Association of Surgeons of South Africa (M.A.S.A.) Joint Lectures. The next lecture in this series will be held on Wednesday 25 May at 5.30 p.m. in the E-floor Lecture Theatre, Groote Schuur Hospital, Observatory, Cape. Mr. P. Helman will speak on 'Breast cancer—aspects of local recurrence'. All members of the Medical Association are welcome.

* * *

Tak Noord-Transvaal (M.V.S.A.). Dr. Douglas Robb, Sims se Reisende Professor, van Nieu-Seeland, sal vanaf 30 Mei tot 1 Junie in Pretoria wees. Op Woensdagaand, 1 Junie, sal hy op 'n buitengewone vergadering van die Tak die lede toespreek oor ‚Maori *versus* White—the incidence of surgical diseases'.

* * *

Southern African Cardiac Society. A clinical scientific meeting of the Southern African Cardiac Society was held at Groote Schuur Hospital, Observatory, Cape, on the evening of 28 April. The following papers were read: (1) Dr. C. Rainer-Pope—'A case of tetralogy of Fallot with corrected transposition and atrial septal defect. (Investigations by cardiac catheterization, angiocardiography and full dye-studies confirmed the lesions.) (2) Dr. Walter Beck described a case of total anomalous pulmonary venous drainage, confirmed by cardiac catheterization and full dye-studies with cardiogreen.

The Chairman, Dr. M. Nellen, announced that the Lederle Laboratories of America have kindly donated money, as have the Burroughs Wellcome Foundation, to subsidize a Cardiac Symposium to be held in Cape Town in the last week of October 1960. It has not yet been decided how many days the Congress will cover, but members of the Cardiac Society are asked to inform the Chairman, c/o Cardiac Clinic, Groote Schuur Hospital, Observatory, Cape, of their intention to present papers and also to indicate the titles. Titles should be submitted before 30 June 1960. Secretaries of the Provincial Sections will be notified of further arrangements.

It was further announced that the South African Society of Cardiological Technicians is now well underway and that lectures have started in Cape Town.

* * *

Gut—Journal of the British Society of Gastroenterology. The British Society of Gastroenterology and the British Medical Association are joining forces to produce a new quarterly Journal *Gut*, which will be of great value to physicians, surgeons, pathologists and radiologists.

There are in gastro-enterology, as in so many other branches of medicine, new developments arising out of new techniques and out of the application of new knowledge in other fields to the study of the disorders of the gastro-intestinal system.

The object of *Gut* is to publish original papers and reviews concerned with practice and research in the field of gastro-enterology. The field is that of alimentary, hepatic, or pancreatic disease, and papers may cover the medical, surgical, radiological and historical aspects. They may also deal with the basic sciences concerned with the alimentary tract, including experimental work. Reports of single cases which are of interest in relation to a wider field of research will be published from time to time. A section will be devoted to short papers on laboratory and surgical techniques and methods of investigation where these are not part of a larger survey.

A distinguished editorial committee has been appointed to direct the progress of the Journal; it is led by Mr. Harold C. Edwards, as Editor, and Dr. F. Avery Jones as Editorial Secretary. The new Journal will be a substantial publication; the first issue will contain about 86 pages of text, quarto in format, and will be fully illustrated. The Journal will appear in March, June, September, and December of every year.

Papers published in the first issue of *Gut* (March 1960) cover the following subjects: History of the British Society of Gastroenterology; Early investigations of haematemesis; The incidence of chronic peptic ulcer forms at necropsy; Observations on blood group distribution in peptic ulcer and gastric ulcer; Serotonin, bananas, and diarrhoea; Diagnostic significance of d. xylose excretion test; Intestinal pseudo-obstruction with steatorrhoea; Coeliac disease: histopathological findings in the small intestinal mucosa as studied by peroral biopsy technique; A study of the pancreatic response to food after gastrectomy in Man; The effect of corticotrophin and corticoids on secretion from denervated gastric pouches in dogs; Multiple endocrine adenoma syndrome; Volvulus of the small intestine in adults; Annual Meeting of the British Society of Gastroenterology.

The annual subscription to *Gut* is £3 0s. 0d. Orders should be sent to the British Medical Association, Tavistock Square, London, W.C.1.

NEW PREPARATIONS AND APPLIANCES : NUWE PREPARATE EN TOESTELLE

BARDIC DESERET INTRACATH

Gurr Surgical Instruments (Pty.) Ltd., introduce a new IV catheter placement unit, which is said to greatly simplify intravenous therapy. Sterile-packaged and ready for use, the Bardic Deseret Intracath is a soft, pliant plastic fitted inside the lumen of an intravenous needle.

When a vein is punctured with this needle, the catheter advances through the needle approximately 2 inches into the vein. After the needle is removed, the Intracath remains in position inside the vein. The catheter's flared proximal end seats snugly into the needle hub as the needle is withdrawn. In this way, the needle becomes an adapter for any intravenous-therapy set.

Among the advantages of the device is that it is said to eliminate venous cut-down and possible sacrifice of a vein. No armband or other restraint is needed. Discomfort and danger of a sharp, rigid needle in the vein is avoided. Also, because the catheter may be left in the vein for several administrations, there is less trauma, minimized reactions, and less frequent vein punctures.

Being a complete, sterile unit the Intracath does away with scrubbing and wearing gloves. It also simplifies preparation and saves many hours of attendant care.

The Bardic Deseret Intracath is obtainable from Gurr Surgical Instruments (Pty.) Ltd., P.O. Box 1562, Johannesburg.

DEGORAN BITABS

Wanders, of Switzerland, announce the introduction of Degoran Bitabs for the symptomatic treatment of coughs, colds and influenza, and supply the following information:

Degoran enables the treatment of all symptoms at the same time. It relieves promptly all the distressing manifestations associated with influenza and catarrh. Furthermore, prolonged effect over 6 - 8 hours is obtained from one bitab (double tablet).

Degoran contains triaminic for its decongestive and secretion-inhibitory effect; noscapine for its soothing action on the cough reflex; trepin hydrate an effective expectorant; and paracetamol for its quicker antipyretic effect free from the side-effects of aspirin. Added to this is the convenience of giving Degoran in 1 bitab which confers the advantages of graduated and timed release of the active principles over a period of 6 - 8 hours.

Degoran is indicated for coughs, colds, influenza, and their associated symptoms—running of the nose, fever, headaches, myalgia, etc. It is supplied in bottles of 24 tablets. The usual dosage for adults is 1 or 2 Degoran Bitabs 3 times daily and for children (6 - 12 years) 1 - 3 bitabs daily.

Westdene Products (Pty.) Ltd., P.O. Box 7710, Johannesburg, and branches, the sole South African distributors, will be happy to supply literature and samples on application.

CORRESPONDENCE : BRIEWERUBRIEK

CYTOSTATIC PREPARATION CYTOXAN/ENDOXAN

To the Editor: You will have noticed that recently a SAPA-Associated Press cable from the USA concerning new cytostatic preparations based on nitrogen mustard has been given considerable publicity in the lay press of this country, and special reference has been made to a promising preparation *Cytoxan* (brand), see, for example the *Pretoria News* of 12 April 1960, page 6, 'Gas is ally in bid to beat cancer'.

To avoid confusion amongst medical practitioners in South Africa, we wish to advise that this preparation is also available to the medical profession here under its original name *Endoxan*. Cytoxan is the brand used in the United States for the same product.

Endoxan/Cytoxan has been developed in the research laboratories of a German pharmaceutical house, Asta-Werke A.G., Brackwede. Clinical tests are also being conducted in teaching hospitals of this country, and a first report has been published in the issue of *Geneeskunde* for 27 February 1960 (**2**, 40).

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ARTIFICIAL ELECTRONIC LARYNX

The Secretary for Health of the Union of South Africa has kindly forwarded to the *Journal* a copy of a letter addressed to the Department of External Affairs by the Embassy of the United States of America. This letter is reproduced below:

'The Embassy of the United States of America presents its compliments to the Department of External Affairs of the Government of the Union of South Africa and has the honour to advise that it has received a communication from its Government with regard to the following matter.

'Western Electric Company, a United States corporation, manufactures an artificial electronic larynx which, for humanitarian purposes, it has been selling at $75.00, its manufacturing cost. The company has received many inquiries from persons abroad who are interested in purchasing this device and would like to be able to comply with such requests, but has been unable to make such sales abroad on its own account. Unfortunately, because of the relatively limited market for a device of this kind, agents would not be interested in handling it except at a very high rate of profit, which the company wishes to avoid. The Department of State is exploring the matter to determine whether or not the World Health Organization might aid in the foreign distribution of this device.

'The Embassy has been specifically requested, however, to approach the Government of the Union of South Africa in regard to this matter to ascertain whether or not, through one of its agencies, it would be in a position to facilitate the distribution of this device in this country. It has been emphasized to the Embassy that this is not a commercial venture and that the interests of the Department of State in transmitting this inquiry are merely to enable persons abroad to have the benefit of being able to purchase this artificial electronic larynx at cost price.

'The Embassy would appreciate it if the Department of External Affairs could bring this to the attention of the appropriate agency for such consideration as would seem to be warranted.

Embassy of the United States of America
Pretoria
1 April 1960'